

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **56414** **S**

PLACE OF DEATH

County of Shoshone
City of Mallice

CERTIFICATE OF DEATH

Registration District No. 72
Primary Registration District No. 1014
(No. Mallice Hospital)

Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Mary Beaton

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of none
6 DATE OF BIRTH (month, day and year) Still Born
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mallice
(State or country) Idaho

PARENTS

10 NAME OF FATHER Jas. A. Beaton
11 BIRTHPLACE OF FATHER (city or town) Missouri
(State or country)
12 MAIDEN NAME OF MOTHER Agnes Wheatley
13 BIRTHPLACE OF MOTHER (city or town) Nullan Idaho
(State or country)

14 Informant Mrs. M. A. Harwood
(Address) Nullan Idaho

15 Filed Jan 20, 1927 Registrar [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 16 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to Jan 16, 1927,
that I last saw h_____ alive on _____, 19____,
and that death occurred, on the date stated above, at 11 p m.
The CAUSE OF DEATH* was as follows:

Still born -

CONTRIBUTORY (Secondary) Difficult labor (duration) _____ yrs. _____ mos. _____ ds.
of old cessation (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) James R. Brown, M. D.
17, 1927 (Address) Mallice

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Nullan Ida Date of Burial Jan 20 1927
20. Undertaker Hard Med Co Address Mallice Idaho

MAR 13 1990

MAR 13 2001

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of, same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FORM V. S. No. 5

RECEIVED MAR 12 1927 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bingham
City of ShelleyRegistration District No. 121Primary Registration District No. 2194

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Parker RichardsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 56530Registered No. 31

If death occurred in a hospital, institution or camp, give the NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Feb 11 1927
(Month) (Day) (Year)

7. AGE

Born dead
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Alfred W. Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ma Benjamin

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) * Alfred W. Richardson
(Address) Shelley, Idaho

15.

Filed Feb 13 1927 Mr. Walter E. V. V.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Born dead to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Hypertension of Mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

F. E. Roberts M. D.Feb 12 1927 Address Shelley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley, Idaho Feb 13 1927

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No.

56722 S

Local Registrar's No. 15

PLACE OF DEATH

County of Twin FallsCity of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37Primary Registration District No. 2055(No. R. R. Laurie)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME

(a) Residence. No. Twin Falls R.R.

St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of✓

6 DATE OF BIRTH (month, day and year)

Feb 22 - 1927

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.000

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Twin Falls Idaho

10 NAME OF FATHER

William A Hofer11 BIRTHPLACE OF FATHER (city or town)
(State or country)Falls City Neb.

12 MAIDEN NAME OF MOTHER

Charlotte Blending13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Kansas City Mo.

14 Informant

William A. Hofer

(Address)

Twin Falls Idaho

15 Filed

3 10

1927

John F. Long

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 22
(Month)22
(Day)1927
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 22, 1927, to Feb 22, 1927.that I last saw her alive on Born Dead, 1927.and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Strangulation during delivery.(duration) yrs. mos. ✓ ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. ✓ ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Shirley L. Hofer, M. D.22 27 19 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls Cemetery2/23 1927

20. Undertaker

Blue & Co.

Address

Twin Falls

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

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term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 57196**

PLACE OF DEATH

County of Lamson
City of Nampa

Registration District No. 1006
Primary Registration District No. 1006

Local Registrar's No. 238

(No. Naperville)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence No. 14 miles south of Nampa, Idaho

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April, 29-1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
1 4 1 1 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa, Idaho10. NAME OF FATHER Floyd Piersol11. BIRTHPLACE OF FATHER (city or town) (State or Country) Blond12. MAIDEN NAME OF MOTHER Miss Knapp13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho14. Informant Floyd Piersol (Address) Nampa, Idaho15. Filed 5-5-27 19 27 Mac Kerby Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 29 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-28, 1927 to 4-29, 1927

that I last saw him alive on 4-29, 1927and that death occurred, on the date stated above, at 7 2 m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Robinson M. D.4/29, 1927 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kohlerburg, Penn 5-1-27
4-29 1927

20. Undertaker

Address

F. W. Robinson Nampa, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-25
RECEIVED APR 28 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S57328**
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Washington
City of Cambridge
Registration District No. _____
Primary Registration District No. _____
(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH. Apr 18 1927
(Month) (Day) (Year)

7. AGE _____
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION na
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE Cambridge Ida
(State or Country)

10. NAME OF FATHER Wade Smith

11. BIRTHPLACE OF FATHER Kelburg Ida
(State or Country)

12. MAIDEN NAME OF MOTHER Vera Godlone

13. BIRTHPLACE OF MOTHER Cambridge Ida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wade Smith
(Address) Cambridge Idaho

15. 422-27
Filed _____ 1927 P. W. H. Egan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April-18-27
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-18-27 191, to 4-18-27 191, that I last saw still-born 191, and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows: Asphyxia-
prolonged cord.

(Duration) Yrs. mos. ds.
Contributory prolonged cord
(Secondary) Breech-presentation
(Duration) Yrs. mos. ds.
(Signed) P. W. H. Egan M. D.
19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death...yrs...mos...days In the State...yrs...mos...days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cambridge DATE OF BURIAL Apr 19 1927

20. UNDERTAKER P. W. H. Egan ADDRESS Cambridge

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery, and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc.; all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED JUN 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 57539**

PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 2005Local Registrar's No. 58(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Hogg

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE — 5. Single, Married, Widowed, or Divorced (write the word) —5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)10. NAME OF FATHER J. J. Hogg11. BIRTHPLACE OF FATHER (city or town) not known
(State or Country)12. MAIDEN NAME OF MOTHER Mary Elizabeth Burnett13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Ed M. Wallace
(Address) Huston Idaho15. Filed 5-25-1927 John B. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

still born premature(duration) yrs. mos. ds.
CONTRIBUTORY mother had uremia(Secondary)
convulsions (duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. B. Meyer M. D.
5-28-1927 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill Date of Burial 5-25 192720. Undertaker C. E. Eckham Address Caldwell, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 57540**

PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 2005Local Registrar's No. 57

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hogg

(a) Residence. No. _____ St. _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) _____
(State or country) Idaho

10. NAME OF FATHER E. P. Hogg

11. BIRTHPLACE OF FATHER (city or town) _____
(State or Country) not known

12. MAIDEN NAME OF MOTHER Mary Elizabeth Burnett

13. BIRTHPLACE OF MOTHER (city or town) _____
(State or Country) Idaho

14. Informant Ida M. Wallace
(Address) Huston Idaho

15. Filed 5-25, 1927 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 1927

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was, as follows:

Still born premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) mother had uricemicCarbuncles (duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____ M. D.

5/28, 1927 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Canyon HillMay 25 1927

20. Undertaker

Address

C. J. BeckhamCaldwell, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACED IN RECEPTION, MAY 14 1927

County of *Madison*

City of *Reynolds*

Registration District No. *100*

Primary Registration District No. *2178*

DO NOT WRITE IN THIS SPACE

State File No. *S 57700*

Local Registrar's No. *34*

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. *Pratt St - Reyn.* St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *W* 5. Single, Married, Widowed, or Divorced (write the word) *Male*

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) *May 5 1927*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) *Reynolds Ida*

10. NAME OF FATHER *Fred. A. Plucas*

11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Reynolds Ill.*

12. MAIDEN NAME OF MOTHER *Mary - Thornton*

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Colorado*

14. Informant *Fred A. Plucas* (Address) *Reynolds Ida*

15. Filed *5/5*, 19 *27* *J. Young* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 5 1927*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 5 1927* to *May 5 1927* that I last saw him alive on *still born*, 19 *27*

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still-born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) *A. Sutherland* M. D. *5/5*, 19 *27* (Address) *Reynolds Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Reynolds* Date of Burial *5/5 1927*

20. Undertaker *J. Young* Address *Reynolds*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-19

RECEIVED JUN 10 1927

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Power
City of Am. Falls

Registration District No. 23
Primary Registration District No. 2072
(No. _____ St.)

State File No. S 57733
Local Registrar's No. 214

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

no name (Joanna)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)

6. DATE OF BIRTH

May 30 1921
(Month) (Day) (Year)

7. AGE

Shelborn IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm. Gasman

11. BIRTHPLACE OF FATHER

(State or Country)

S. Dak.

12. MAIDEN NAME OF MOTHER

Mary Knapp

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Gasman
(Address) Am. Falls

15.

Filed May 30 19 27 Genevieve Noth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 30 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19. ,
that I last saw h. alive on 19. ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Shelborn
chills

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Muel M. D.
19 27 (Address) Am. Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Am. Falls

DATE OF BURIAL

5/31 1927

20. UNDERTAKER

Family

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

RECEIVED JUL 19 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 57826 S

County of Ada

Registration District No. 2

City of Boise

Primary Registration District No. 1004

Local Registrar's No. 134

(No. S. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lyle Doolittle

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15 - 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida (State or country)

10. NAME OF FATHER Edwin Doolittle

11. BIRTHPLACE OF FATHER (city or town) Wis. (State or Country)

12. MAIDEN NAME OF MOTHER Adeline Strickler

13. BIRTHPLACE OF MOTHER (city or town) Wis. (State or Country)

14. Informant Edwin Doolittle (Address) 1318 Idaho, Boise

15. Filed 6-16-1927 Paula McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 15 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Chas. J. Penney, M. D.

(Address) 19

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery 6/16 1927

20. Undertaker Schuchert & Davis Address Boise, Ida

W. C. Cullen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 58018**

PLACE OF DEATH

County of Minidoka
City of Paul

Registration District No. 19
Primary Registration District No. 2013

Local Registrar's No. 17

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Brown

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. Single Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Paul Ida
(State or country)

10. NAME OF FATHER Geo M Brown

11. BIRTHPLACE OF FATHER (city or town) Wyoming
(State or Country)

12. MAIDEN NAME OF MOTHER Abnera Winn

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Geo M Brown
(Address) Paul Ida

15. Filed 6-17, 1927 E. E. Chumore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

still born

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) A. H. Cooper M. D.
June 16, 1927 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Paul Ida Date of Burial June 16, 1927

20. Undertaker D. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **S 58030**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1209
(No. St Joseph Hospital.)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Stillborn White.

(a) Residence. No. _____ St. Webb, Idaho.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE Indian. 5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 6/6/27.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston, I
(State or country) Idaho.

10 NAME OF FATHER Joseph White.

11 BIRTHPLACE OF FATHER (city or town) Idaho.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Hill.

13 BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or country)

14 Informant H. B. W. D. Sam
(Address) Lapwai, Idaho.

15 Filed July 3, 1927 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
June 6th, 1927.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) John Haller
6/7/27. 19____ (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

19 Place of Burial, Cremation, or Removal

Date of Burial

Webb, Idaho

6/7/27. 19____

20. Undertaker

Address

Brower-Wann Company.

Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 13 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S58710**

County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1061
(No. Providence Hospital)

Local Registrar's No. 97

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Brash

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

16 DATE OF DEATH 8 6 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of none

17 I HEREBY CERTIFY, That I attended deceased from Aug 6th, 1927, to Aug 6th, 1927, that I last saw him alive on Aug 6th, 1927, and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day and year) Aug 6 1927
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Prematurity

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) Hydramnion in utero

9 BIRTHPLACE (city or town) Wallace
(State or country) Idaho

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted if not at place of death? _____

10 NAME OF FATHER Ralph H. Brash

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) Utah
(State or country) _____

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER Ruth Isabelle

What test confirmed diagnosis? (Signed) W. C. Ludwig, M. D.
8/7, 1927 (Address) Kellogg 2da

13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant Ralph H. Brash
(Address) Kellogg

19 Place of Burial, Cremation, or Removal Wallace Idaho Date of Burial Aug 8 1927

15 Filed Aug 6 1927 W. C. Ludwig
Registrar

20 Undertaker Hard Und Co Address Wallace Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 22 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 58838**

PLACE OF DEATH

County of Bonneville
City of Idaho Falls Rt. #5

Registration District No. 23
Primary Registration District No. 21 N O

Local Registrar's No. 109

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Nelson

(a) Residence. No. Idaho Falls Route #5 St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 13, 1927

7. AGE Years Months Days If LESS than 1 day, min. hrs. or
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho

10. NAME OF FATHER Arthur L. Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sandy, UTAH

12. MAIDEN NAME OF MOTHER Madeline Stucki

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Arthur L. Nelson
(Address) Idaho Falls, Idaho

15. Filed 8/16, 1927 (J. A. Wood) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 13 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Still born. Abortion of
Circulation due to malposition.
Baby was delivered dead

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? J. A. Wood M. D.
(Signed)

Aug. 13, 1927 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Coltman, Idaho

Aug. 13 1927

20. Undertaker

J. A. Wood

Address

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 28 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File **59244**

PLACE OF DEATH

County of Saratoga
City of Burley Reg. #1

Registration District No. 117
Primary Registration District No. 2196

Local Registrar's No. 927

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Alldaffer

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX F 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 26/1927
7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still Born
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Burley

PARENTS

10. NAME OF FATHER Vacy D. Alldaffer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Viola May Gummerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant J. D. Alldaffer (Address) Burley Idaho.

15. Filed Sept. 27, 1927 Dr. J. C. Patterson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 26 1927
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 26, 1927, that I last saw him on Sept 27, 1927, and that death occurred, on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Still born

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of no
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) J. E. Olsen M. D.
9/27, 1927 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Ida Date of Burial Sept 28 1927
20. Undertaker D. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate which is signed only by a midwife.

FORM V. S. J. 5-25 M. 1-16-13

RECEIVED

OCT 17 1927

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.....
 Registration District No. 102
 County of Fremont Primary Registration District No. 6
 City of Archie (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn Akers

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. S 59264

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
 (Write the word.)

6. DATE OF BIRTH.

Aug 18 1927
 (Month) (Day) (Year)

7. AGE

Still Born
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Fremont Idaho

10. NAME OF FATHER

Paul Akers

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Anna Brasier

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert Brasier

(Address) Island Park Idaho

15.

Filed

9/17

1927

W. H. Akers

Local Registrar

16. DATE OF DEATH

Aug 18 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 191 to Stillborn 191.

that I last saw h. alive on 191.
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born Due perhaps to
poisoning from long labor and
was wrapped tightly around
neck. (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. H. Akers M. D.

1927 (Address) Island Park Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View

DATE OF BURIAL

Aug 15 1927

20. UNDERTAKER

Walter Akers

ADDRESS

Island Park Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such; if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5 **RECEIVED NOV 14 1927** **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone
City of Mellace

Registration District No. 70

Primary Registration District No. 10

(No. St.)

State File No. S 59370

Local Registrar's No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Catheryn Ann Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Oct 3 1927
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mellace Idaho

10. NAME OF

Father Ivan J. Green

11. BIRTHPLACE

OF FATHER Sweden

(State or Country)

12. MAIDEN NAME

OF MOTHER Dorothy Mc Kinney

13. BIRTHPLACE

OF MOTHER Washington

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ivan J. Green

(Address) Stacey Idaho

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 3 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1927 to Oct 3rd 1927

that I last saw h. Steel town 1927, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Birth shock. Breech delivery.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Friedman M. D.

1927 (Address) Kellogg Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greeny Idaho Oct 5 1927

20. UNDERTAKER

ADDRESS

M. C. Shambler Kellogg Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1928

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 59781**County of **BANNOCK**
City of **POCATELLO**Registration District No. **28**Primary Registration District No. **2161**Local Registrar's No. **5786**(No. **GENERAL HOSPITAL**)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **INFANT WALTON**

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE** 4. COLOR OR RACE **WHITE** 5. Single, Married, Widowed, or Divorced (write the word) **SINGLE**5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) **DEC. 21, 1927**7. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILLBORN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **POCATELLO**
(State or country) **IDAHO**10. NAME OF FATHER **ARCHIE WALTON**11. BIRTHPLACE OF FATHER (city or town) **ELBURN**
(State or Country) **WYOMING**12. MAIDEN NAME OF MOTHER **HAZEL FENWICK**13. BIRTHPLACE OF MOTHER (city or town) **NAMPA**
(State or Country) **IDAHO**14. Informant **ARCHIE WALTON**
(Address) **112 - WEST GOULD POCATELLO**15. Filed **12/24, 1927** **Arthur W. Hall**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

DEC. 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 21 1927 **Dec 21 1927**
that I last saw him **Dec 21 1927**

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? **no** Date of _____Was there an autopsy? **no**

What test confirmed diagnosis?

(Signed) **A. W. Brothers** M. D.
12-24-27 (Address) **Pocatel**

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **MOUNTAIN VIEW CEMETERY** Date of Burial **DEC. 22, 1927**20. Undertaker **ARTHUR W. HALL** Address **POCATELLO IDAHO**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JAN 15 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S59852**Local Registrar's No. **48**

PLACE OF DEATH

County of Burnah
City of St. MarcusCERTIFICATE OF DEATH
Registration District No. 32
Primary Registration District No. 2049
(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lester Cheney

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Nov 30 - 19277 AGE 1 Years 11 Months 30 Days 1 If LESS than 1 day, hrs. or min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) St. Marcus
(State or country) Idaho10 NAME OF FATHER James M. Cheney11 BIRTHPLACE OF FATHER (city or town) Barnett
(State or country) Mont12 MAIDEN NAME OF MOTHER Alice LaHair13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country) Idaho14 Informant James M. Cheney
(Address) St. Marcus Id15 Filled Dec 1 1927 Osullivan
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 30 1927
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 11-30, 1927, to 11-30, 1927.
that I last saw him alive at no time, 1927,
and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Toxic Nephritis in motherCONTRIBUTORY (Secondary) Nothing aside from above (duration) yrs. mos. 10 ds.18 Where was disease contracted If not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? NoneWhat test confirmed diagnosis? Medical tests on mother(Signed) A. B. ..., M. D.12/1, 1927 (Address) St. Marcus, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19 Place of Burial, Cremation, or Removal Woodlan Date of Burial Dec 1 192720. Undertaker Mitchell & Merage Address St. Marcus
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC'D JAN 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 59990**

PLACE OF DEATH

County of Kootenai
City of Coeur D' Alene

CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1051
(No. Reed Hospital)

Local Registrar's No. 156

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Buckle

(a) Residence. No. Coeur D' Alene, Ida. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 21, 1927

7 AGE Years Months Days 0 If LESS than 1 day or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur D' Alene
(State or country) Ida.

10 NAME OF FATHER John Buckle

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Nell Steele

13 BIRTHPLACE OF MOTHER (city or town) Ida.
(State or country)

14 Informant John Buckle
(Address) Coeur D' Alene, Ida.

15 Filed 12/31, 19 27 DD Drumm
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 21 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1927, to Dec. 21, 1927, that I last saw him alive on his wife's line, 1927, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born due to prolonged labor.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold J. Sturges, M. D.
Dec. 22, 1927 (Address) Coeur D' Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial 12/22 1927

20 Undertaker IPB Mosney Address Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "~~PUERPERAL peritonitis,~~" etc. ~~all diseases~~ resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60427

S

PLACE OF DEATH

County of Boone

CERTIFICATE OF DEATH

Registration District No. 123

Local Registrar's No. 1

City of _____

Primary Registration District No. 2201

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME _____

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12/13/27

7 AGE Years Months Days If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cataldo Idh
(State or country)

10 NAME OF FATHER Andrew H. Kindred

11 BIRTHPLACE OF FATHER (city or town) Preston Mo.
(State or country)

12 MAIDEN NAME OF MOTHER Edie Layth

13 BIRTHPLACE OF MOTHER (city or town) Byron Chapman
(State or country)

14 Informant Andrew H. Kindred
(Address) Cataldo Idh

15 Filed Jan. 15, 1928 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 23 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Stip-born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. P. Measim, M. D.

12/29, 1927 (Address) Kellogg Idh

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Buried 12/13/27
20. Undertaker Address

P. A. Stout Kellogg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

154-210-001-766
PLACE OF BIRTH

RECEIVED FEB 9 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS-

S

CERTIFICATE OF BIRTH

148354

County of Ada

City of Bain

No. 416 Franklin St.

Registration District No. 2

File No. 15

Hospital

Primary Registration District No. 1004

Registered No. 15

FULL NAME OF CHILD

Dorothy Jean Anderson

(Certificate of no value without full name of child.)

Sex of
Child

Female

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Jan. 10 1927

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth. 4

Number of child of this mother now living, including present birth. 3

FULL
NAME

Deland Anderson

FATHER

FULL
MAIDEN
NAME

Mary Powell

MOTHER

RESIDENCE

416 Franklin St.

RESIDENCE

416 Franklin St.

COLOR

White

AGE AT LAST
BIRTHDAY

3.5
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

3.6
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Physician

OCCUPATION

Physician

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Stillborn at 6:00 A. M.
(born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

D. W. Anderson
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

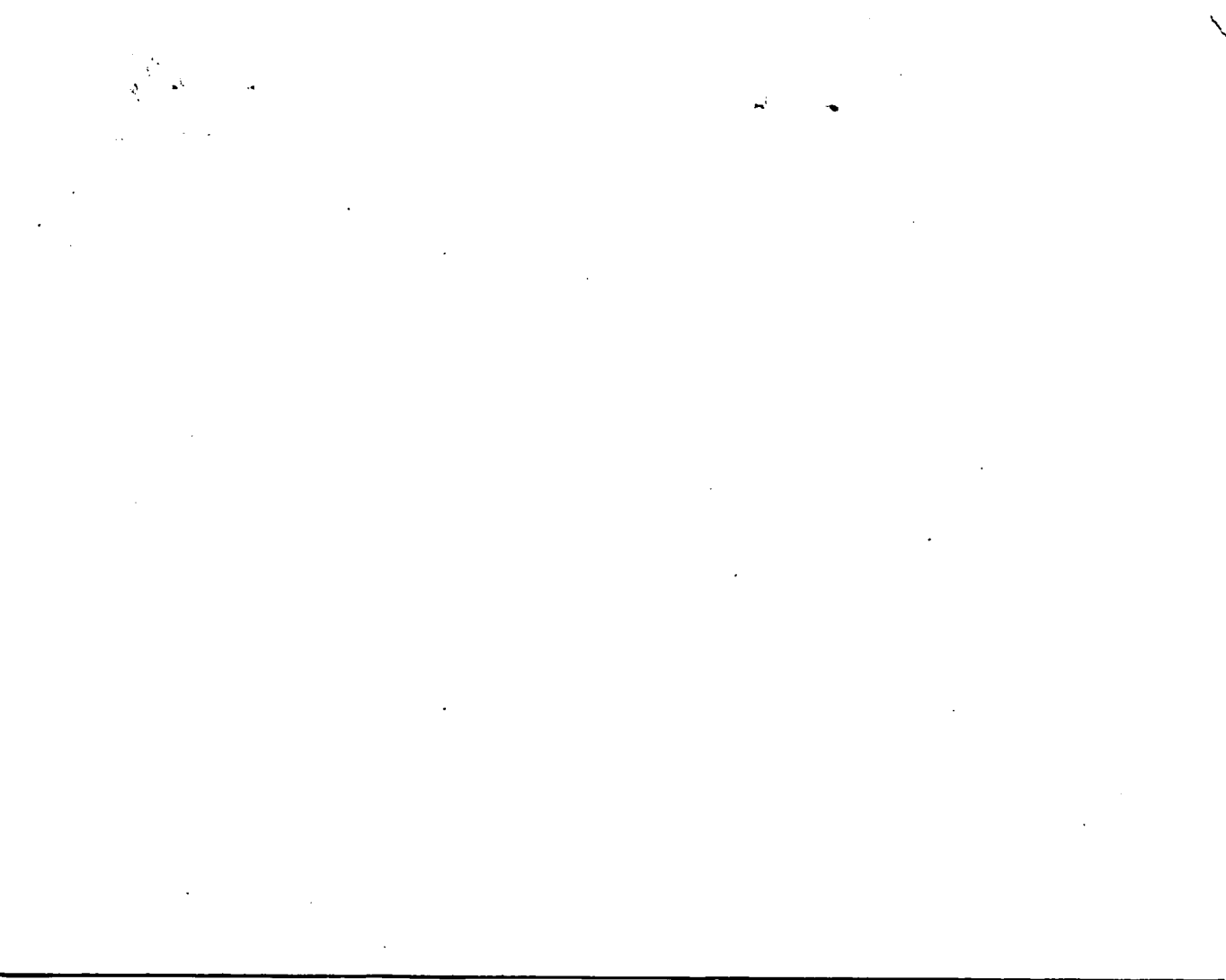
214 S. 4th Bldg. Bain

Filed 1-20 1927

R. H. Pratt

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 9 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56044

County of Ada
City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1416 W. Franklin)

Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Anderson

(a) Residence. No. 1416 W. Franklin St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Jan. 10 - 1927

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boise Idaho

10 NAME OF FATHER

Ieland A. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Utah

12 MAIDEN NAME OF MOTHER

May Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Utah

14

Informant
(Address)

I. A. Anderson
1416 W. Franklin St.

15

Filed

Jan 10 1927

R. N. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 10 1927
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1927, to Jan. 10, 1927, that I last saw him alive on Dec. 31, 1926, and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Still Birth

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. W. Anderson D.

Jan. 10, 1927 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Memorial Cemetery Jan. 11 1927

20 Undertaker

Address

Sumner & Kneen Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, ~~of~~ Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or ~~At home.~~ If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

719-320-00-294
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S-2

CERTIFICATE OF BIRTH 148360

County of Ada
City of Boise
No. _____ St. _____ Registration District No. 2 State File No. _____
Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 21
FULL NAME OF CHILD Rose Marie Parani

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>1-20-1927</u> (Month) (Day) (Year)
----------------------------	----------------------------------	--	------------------------	--

What bactericidal solution was used in eyes? 1% Silver Nitrate Sol.

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Vincent Parani
RESIDENCE 419 So. 13th St. Boise, Ida.
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Italy
OCCUPATION Restaurant Operator + Cook

MOTHER
FULL MAIDEN NAME Matilda Simpson
RESIDENCE 419 So. 13th St. Boise, Ida.
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Staffordshire, England
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Boise, Idaho on the date above stated. 6:20 P. M.

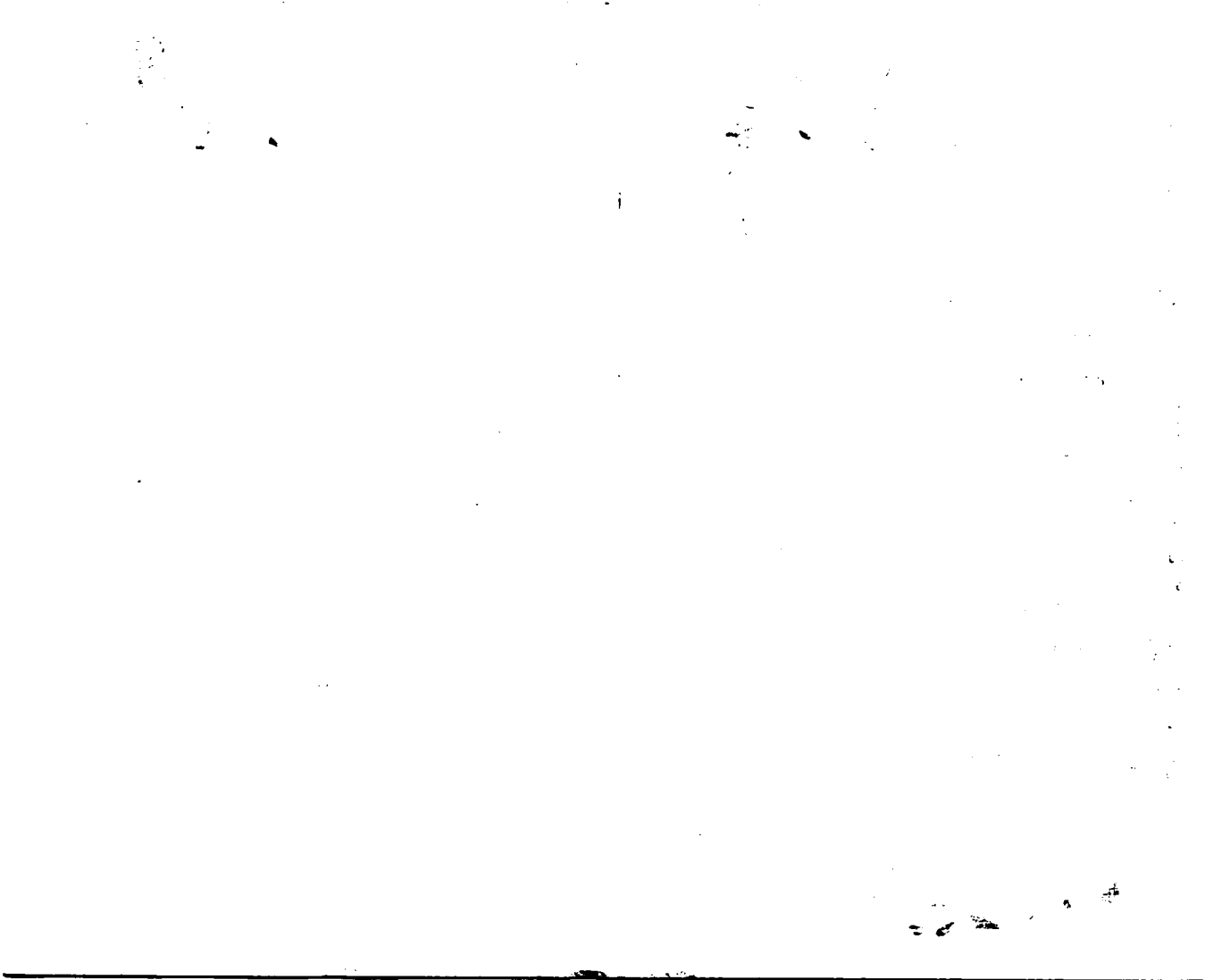
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) T. N. Braxton M.D.
Physician
(Physician or midwife)

Address Boise, Idaho

Filed 1-24-1927 R. H. Pratt
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **56029**

PLACE OF DEATH
County of Idaho
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 20

RECEIVED FEB 9 1927

Primary Registration District No. 1004

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Rose Mary Parani

(a) Residence. No. 419 South 13th St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

16. DATE OF DEATH Jan 20 1927
(Month) (Day) (Year)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan 20, 1927 that I last saw deceased and that death occurred, on the date stated above, at 6:20 p.m.

6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min. 15

The CAUSE OF DEATH* was as follows:
Prematurely, Placenta Previa and Habitual Abortion

8. OCCUPATION OF DECEASED Still born
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

(duration) yrs. mos. ds.
CONTRIBUTORY Cause unknown
(Secondary)

9. BIRTHPLACE (city or town) Boise Ida
(State or country)

18. Where was disease contracted Boise Idaho
if not at place of death?

10. NAME OF FATHER Vincent Parani

Did an operation precede death? No Date of

11. BIRTHPLACE OF FATHER (city or town) Ida
(State or Country)

Was there an autopsy? No

12. MAIDEN NAME OF MOTHER Mahilda Simpson

What test confirmed diagnosis? None

13. BIRTHPLACE OF MOTHER (city or town) England
(State or Country)

(Signed) J. W. Braxton, M. D.
Jan 21, 1927 (Address) Boise Idaho

14. Informant Vincent Parani
(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. Filed Jan 20, 1927 R. H. Pratt
Registrar

19. Place of Burial, Cremation, or Removal St. John's Cemetery Date of Burial 11 22 1927

20. Undertaker Schubert & Davis Address Boise Ida

Braxton

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

396-122-001-466
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of Boise

RECEIVED FEB 9

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 2 State File No. 148371

Hospital St. Luke's Primary Registration District No. 1004 Local Registrar's No. 31

FULL NAME OF CHILD L

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Jan 22 1927</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? L

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth One

FATHER		MOTHER	
FULL NAME <u>Ward Allen Drayton</u>	FULL MAIDEN NAME <u>Alpha Mooney</u>	FULL NAME <u>Ward Allen Drayton</u>	FULL MAIDEN NAME <u>Alpha Mooney</u>
RESIDENCE <u>Boise 2315 Washington</u>	RESIDENCE <u>Boise 2315 Washington</u>	RESIDENCE <u>Boise 2315 Washington</u>	RESIDENCE <u>Boise 2315 Washington</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Missouri</u>
OCCUPATION <u>Clark</u>	OCCUPATION <u>H. wife</u>	OCCUPATION <u>H. wife</u>	OCCUPATION <u>H. wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 00 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. E. Drayton
Drayton
(Physician or midwife)

Address _____

Filed 1-31- 192 7 R. N. Peatt
Registrar. Registrar.

located about 100 mi. down to Tolman off bus 17229

City of _____
County of _____

S

REPLY NAME OF CHILD

What bactericidal solution was used in 1967?

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
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(b)(7)(F) (b)(7)(F) *[Handwritten signature]*
 2011-10-10

10-10-68

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

on the date above stated.

etc. should make this return. A birthborn child is one that neither practices nor

44-38861-1000

DECLASSIFICATION AUTHORITY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **56035** (B)PLACE OF DEATH 9 - 1927
RECORDED FEB 9

County of

Registration District No. 2

City of

Primary Registration District No. 1004Local Registrar's No. 25

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Allen Rudolph Trofel(a) Residence. No. 2315 woodlawn St.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX m 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Ida
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) MO

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) MO14. Informant ward Trofel(Address) 2315 woodlawn15. Filled Jan 22, 19 27 R. H. Trofel
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22, 19 27
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1/22, 19 27, to 1/22, 19 27
that I last saw him alive on Stillborn 1/22, 19 27
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted _____
if not at place of death? _____Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Physical Exam
(Signed) R. H. Trofel, M. D.1/24, 19 27 (Address) 2315 woodlawn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Jan 22 19 27

20. Undertaker

Address

Schubert & Davis Boise

Registrar

Bennett

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

238-203-006-553
PLACE OF BIRTH

RECEIVED FEB 8 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Blackfoot

CERTIFICATE OF BIRTH **148467**

No. Idaho St. Durham Registration District No. 121 State File No. 2

Hospital Idaho Primary Registration District No. 2194 Local Registrar's No. 16

FULL NAME OF CHILD Mormonis Schultz

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Jan 3 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Gottlieb Schultz</u>	<u>Sterling Idaho</u>	<u>Fannie Netzer</u>	<u>Sawader</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u></u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Germany</u>		BIRTHPLACE <u>North Dakota</u>	
OCCUPATION <u>Fanner</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9. P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. W. Mitchell

Address Blackfoot Idaho

Filed Jan 7 1927 Mollie E. Talie

Registrar.

Registrar.

SEP 13 1999

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 8 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **56118**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of BinghamRegistration District No. 121City of Bluff, IdahoPrimary Registration District No. 2194Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed Schultz

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

FemalewhiteSingle

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

15 Filled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1927, to Jan 3, 1927, that I last saw her alive on Jan 3, 1927, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. J. Mitchell, M. D.

_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

Place of Burial, Cremation, or Removal

Date of Burial

Abundant Idaho

19

20. Undertaker

Address

E. J. KirkBluff, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

6-3-1071006-493
PLACE OF BIRTH

RECEIVED FEB 8 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bingham
City of Shelley

CERTIFICATE OF BIRTH 148483

No. _____ St. Registration District No. 121 State File No. 32

Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 32

FULL NAME OF CHILD Baby Sackrell
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? yes Date of birth Jan. 7 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Mark Sackrell</u>		<u>Renetta Miller</u>	
RESIDENCE	<u>Shelley Ida</u>	RESIDENCE	<u>Shelley Ida</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>25</u>	AGE AT LAST BIRTHDAY	<u>26</u>
	(Years)		(Years)
BIRTHPLACE	<u>Blackfoot Ida</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2 A.M. on the date above stated.

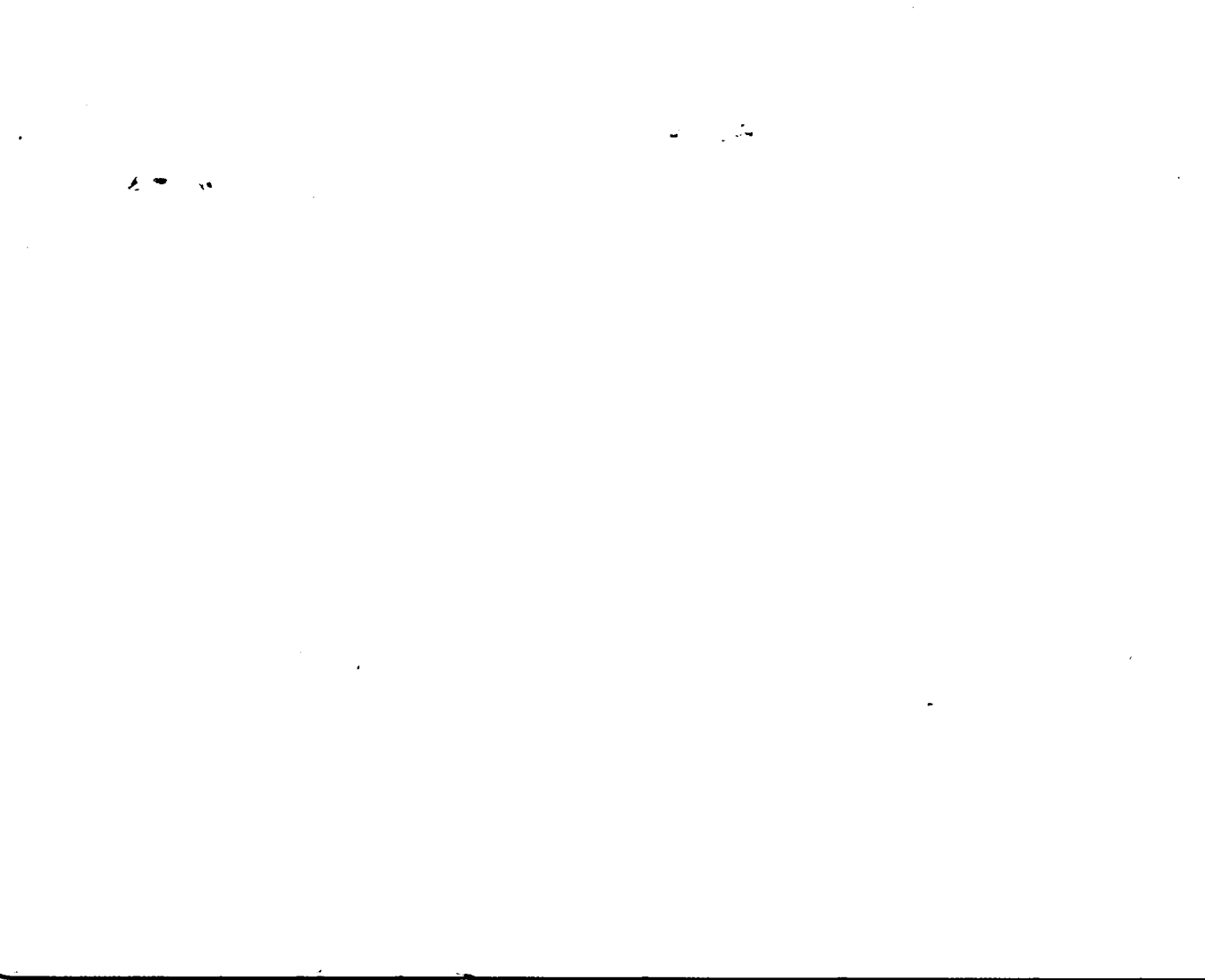
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) D. P. Egbert
Physician
(Physician or midwife)

Address Shelley Ida

Filed Feb. 6 1927 M. C. L. E. T. A. M.
Registrar. Registrar.



RECEIVED FEB 8 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 56123

PLACE OF DEATH

CERTIFICATE OF DEATH

County of BinghamRegistration District No. 121Local Registrar's No. ECity of ShelleyPrimary Registration District No. 2194

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Fackrell

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
Female4 COLOR OR RACE
White5 Single, Married, Widowed,
or Divorced (write the word)
Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) January 7, 19277 AGE Years Months Days
0 0 0
1 If LESS than
or day, hrs.
min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work Baby(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Shelley
(State or country) Idaho10 NAME OF FATHER Mark Fackrell11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho12 MAIDEN NAME OF MOTHER Emmertt Miller13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Utah14 Informant Mark Fackrell(Address) Shelley, Idaho15 Filed Jan 11, 1927 Mrs. Walter E. Peterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 7 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

✓, 19....., to ✓, 19.....

that I last saw h. ✓ alive on ✓, 19.....

and that death occurred, on the date stated above, at 1-15 a.m.

The CAUSE OF DEATH* was as follows:

Stillborn
cause (unknown)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?..... Date of

Was there an autopsy?.....

What test confirmed diagnosis?

Signed) D. H. Egbert M. D.
Jan 7, 1927 (Address) Shelley, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Shelley, IdahoJan. 7 19 27

20. Undertaker

Address

J.A. WoodIdaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

393-209-007-467
PLACE OF BIRTH

RECEIVED

FEB 4 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 57 State File No. 148501
Hospital _____ Primary Registration District No. 2022 Local Registrar's No. 1

FULL NAME OF CHILD

Baby Lilya

(Certificate of no value without full name of child)

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth 1 9 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Lawrence Andrew Lilya
RESIDENCE Beleeme, Ida

MOTHER
FULL MAIDEN NAME Mary Rogers
RESIDENCE Beleeme, Ida

COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:55 A.M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Robert H. Wright-M.D.

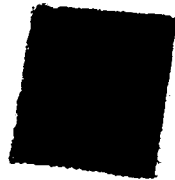
(Physician or midwife)

Address Hailey, Ida

Filed 2-1 1927 Robert H. Wright

Registrar.

Registrar.



RECEIVED FEB 4 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **56137**

PLACE OF DEATH

County of BlaineCity of BeleemeRegistration District No. 57Primary Registration District No. 2022Local Registrar's No. (4) 5(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Lilya

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) 1-9-'27

7 AGE Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Beleeme, Ida
(State or country)10 NAME OF FATHER Lawrence G. Lilya11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)12 MAIDEN NAME OF MOTHER Mary Rogers13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)14 Informant Robert H. Wright, M.D.
(Address) Hailey, Ida15 Filed 2-1 19 27 Robert H. Wright
RegistrarMEDICAL CERTIFICATE OF DEATH 1898

16 DATE OF DEATH

1 9 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

StillbornCONTRIBUTORY Hydrantion
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Robert H. Wright, M.D.
2-10 19 27 (Address) Hailey, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.19 Place of Burial, Cremation, or Removal Beleeme, Ida Date of Burial 1-10 19 2720. Undertaker None Address _____WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

435-251014-799
PLACE OF BIRTH RECEIVED FEB 15 1927 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Canyon
City of Caldwell
No. Caldwell Ida St. Registration District No. 3 State File No. 148623
Hospital _____ Primary Registration District No. 1005 Local Registrar's No. 8

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>F</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Jan 24 1927</u> (Month) (Day) (Year)
-----------------------	------------------------------	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. <u>1</u>		Number of child of this mother now living, including present birth. <u>0</u>	
FATHER FULL NAME <u>O. G. Mc Nab</u> RESIDENCE _____ COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>24</u> (Years) BIRTHPLACE <u>Ida</u> OCCUPATION <u>gen labor</u>		MOTHER FULL MAIDEN NAME <u>Edna Griffith</u> RESIDENCE <u>Caldwell Ida</u> COLOR <u>w</u> AGE AT LAST BIRTHDAY <u>21</u> (Years) BIRTHPLACE <u>Ida</u> OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive { at 8 a. M.
on the date above stated. Stillborn {

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192

(Signature) W. Montgomery

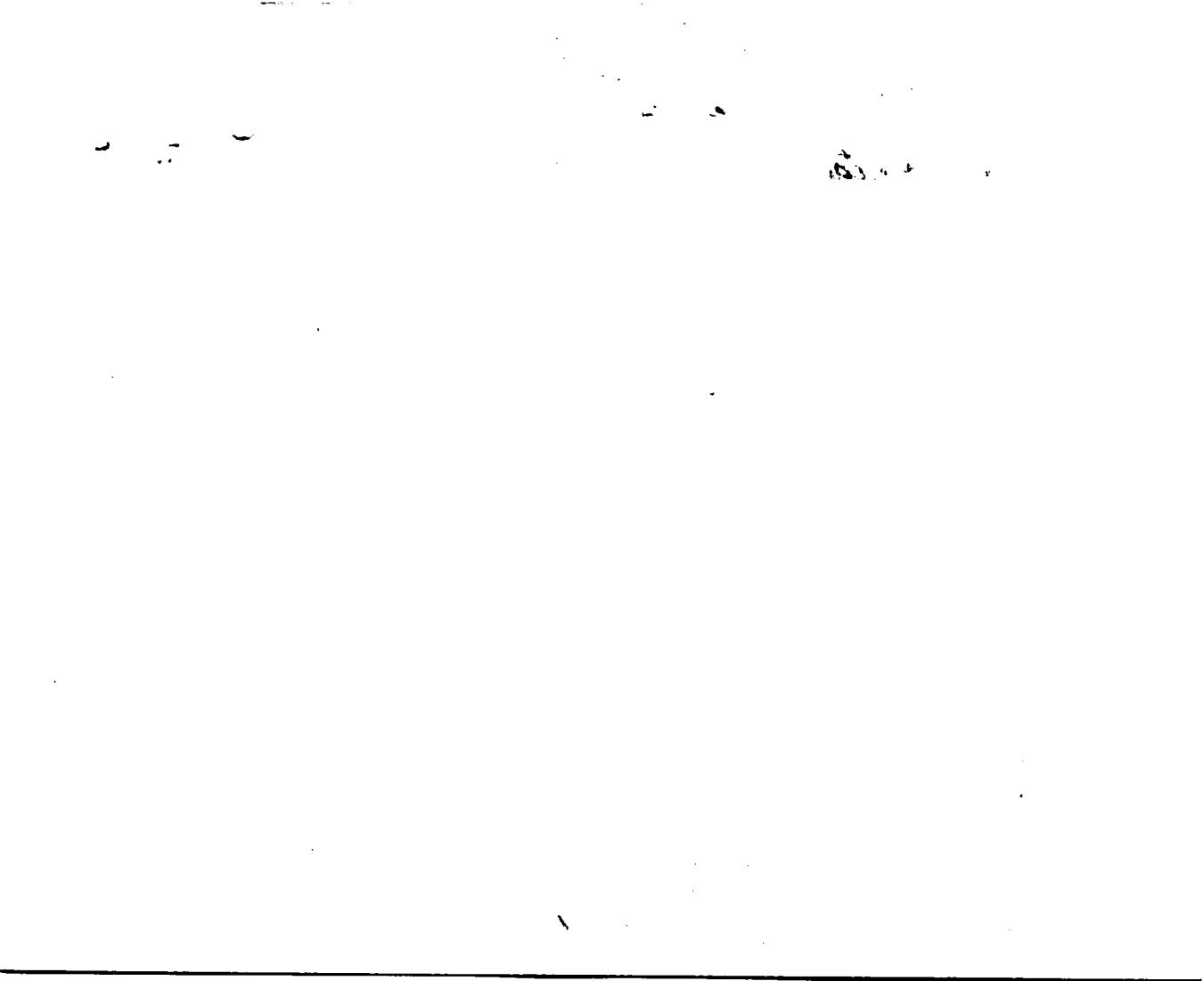
(Physician or midwife)

Address Caldwell Ida

Filed 1-25- 1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 15 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56160

County of Canyon
City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 7

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Mc Nabbs

(a) Residence. No. 1003 Denver St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed 1-25, 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1-24 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Jan 24, 1927, to Jan 24, 1927,
that I last saw him alive on Jan 24, 1927,
and that death occurred, on the date stated above, at 8:50 m.

The CAUSE OF DEATH* was as follows:

Asphyxiation due
Contracted pelvis
maternal

(duration) yrs. mos. ds.

CONTRIBUTORY Contracted pelvis
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Montgomery, M.D.
Jan 24, 1927 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Canyon Hill

1-25, 1927

20. Undertaker

Address

C. V. Beckham

Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

219-124,021-845
PLACE OF BIRTH

RECEIVED FEB 5 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Dayton

CERTIFICATE OF BIRTH

No. 15 St. Registration District No. 2119 State File No. 148717

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 76

FULL NAME OF CHILD George Barn

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth. <u>Jan 14</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	------------------------------	--------------------------------------	------------------------	---

What bactericidal solution was used in eyes? Arg

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Em Barn
RESIDENCE Dayton
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Anna Marie Hunt
RESIDENCE Dayton
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. J. Philford
Physician
(Physician or midwife)

Address

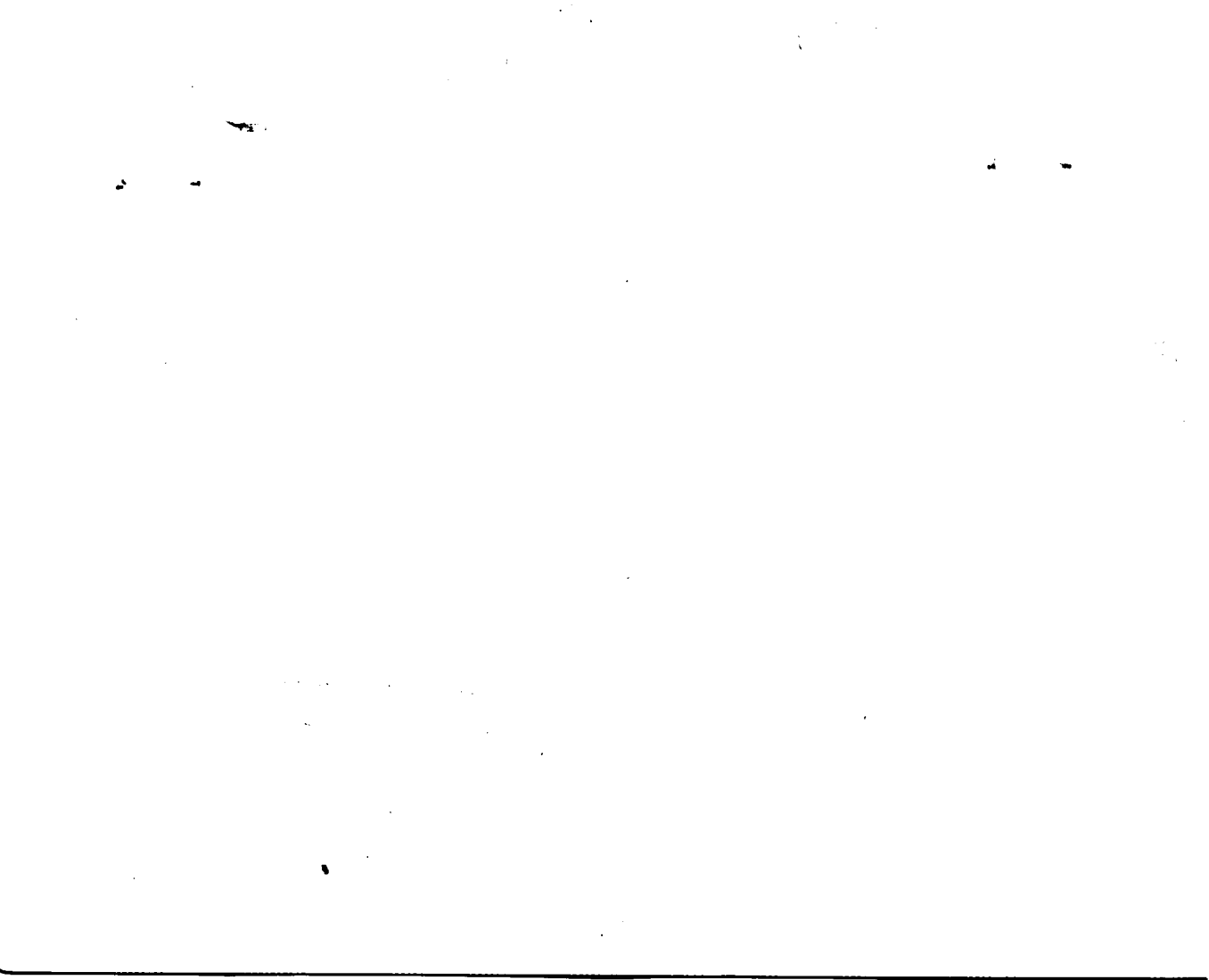
Preston 2da

Filed

Feb. 2 1927

G. R. Butler
Registrar.

Registrar.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-11-12

RECEIVED FEB 5 - CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

Registration District No. 27

City of Dayton

Primary Registration District No. 2119

State File No. 56236

Local Registrar's No. 7

If death occurs away from usual residence, give facts called for under special information.

(No. St.)

2. FULL NAME George Baron --- Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

Jan. 14, 1927

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day show many
hrs. or
min.?

0 Yrs. 0 Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dayton, Idaho

10. NAME OF

Father

E. M. Baron

11. BIRTHPLACE

OF FATHER

Utah

(State or Country)

12. MAIDEN NAME

OF MOTHER

Anna Marie Hunt

13. BIRTHPLACE

OF MOTHER

Utah

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

E. M. Baron

(Informant)

(Address)

Dayton, Idaho

15.

Filed

Feb. 2 1927

A. R. Cuthbert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 14, 1927

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1926 to Jan. 14, 1927

that I last saw him alive on Jan. 14, 1927

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Premature

(Duration) yrs. mos. ds.

(Signed)

E. S. Milford

M. D.

1-14-27 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Hyrum, Utah

DATE OF BURIAL

1-15 1927

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile,**" etc.), "**Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness,**" etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

759-121-024

PLACE OF BIRTH

RECEIVED FEB 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

148767

No. _____ St. Registration District No. 24 State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. 148

FULL NAME OF CHILD Irno Edward Perry
(Certificate of no value without full name of child)

Sex of Child Boy Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth 1-21- 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 10% 90c two 30c

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Alfred C. Perry
RESIDENCE Gordium, Idaho
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Indiana
OCCUPATION Tailor

MOTHER
FULL MAIDEN NAME Florence Oliver
RESIDENCE Gordium, Idaho
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Ohio
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 5 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) J. H. Crowell
MD
(Physician or midwife)

Address Gordium, Idaho

Filed 1-31- 1927 J. H. Crowell

Registrar.

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **56267**
Registered No. **78**

1. PLACE OF DEATH
Gooding RECEIVED FEB 4 1927 24
County of **Gooding** Registration District No. **24**
Primary Registration District No. _____
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Perry

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **boy** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED **single**

6. DATE OF BIRTH

Jan 21 1927
(Month) (Day) (Year)

7. AGE

stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Gooding

10. NAME OF FATHER

A. C. Perry

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Florence Oliver

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Perry

(Address)

Gooding

15.

Filed

1/31

1927

J. H. Crounwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

still born

cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Crounwell M. D.
1/31 1927 (Address) **Gooding, Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding, Ida

DATE OF BURIAL

1/22 1927

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

595-107-033-766
PLACE OF BIRTH

RECEIVED FEB 14 1912

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

148909

County of Madison

City of Reynoldsburg

No. _____ St. _____ Registration District No. 100 State File No. _____

Hospital _____ Primary Registration District No. 2178 Local Registrar's No. 9

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Jan. 7</u> <u>1912</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FULL NAME <u>Walter Henry Vincent</u>	FATHER
RESIDENCE <u>Reynoldsburg</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Ida.</u>	
OCCUPATION <u>Labourer</u>	

FULL MAIDEN NAME <u>Ezzena Gordiffe</u>	MOTHER
RESIDENCE <u>Reynoldsburg</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Ida.</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1000 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. H. Byrd

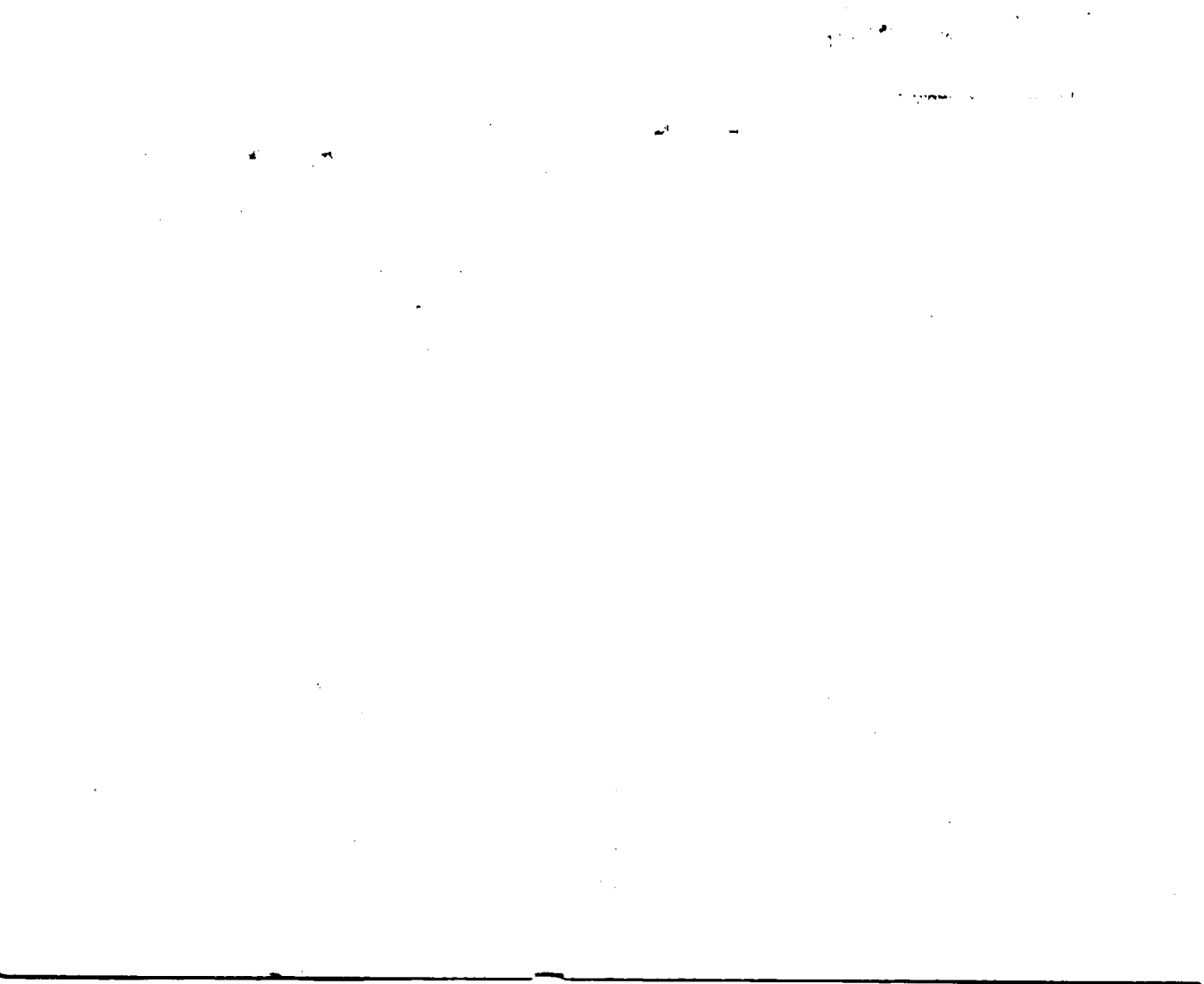
(Physician or midwife)

Address _____

Filed 2/12 1912 7 Reynoldsburg

Registrar.

Registration



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Hay

RECEIVED FEB 14 1927

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Madison.
City of Rexburg.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)

State File No. 56330
Local Registrar's No. 3
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Vincent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant.
(Write the word)

6. DATE OF BIRTH
January 7 1927
(Month) (Day) (Year)

7. AGE
1 Yrs. - Mos. - ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Rexburg, Idaho.

10. NAME OF Father Walter P. Henery Vincent.

11. BIRTHPLACE OF FATHER
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER Emma Goodliffe.

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Vincent

(Address) Rexburg, Idaho.

15. Filed 1/8 1927
Local Registrar W. H. H. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January 7 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h. alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Premature
Stillborn 6 mos.
(Duration) 0 yrs. 6 mos. 0 ds.

Contributory (Secondary)
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) W. H. H. H. M. D.
Feb 1927 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Idaho In the
of death 0 yrs. 0 mos. 0 days. State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rexburg, Idaho. DATE OF BURIAL 1/8/27 19 27

20. UNDERTAKER W. H. H. H. ADDRESS Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

255-723-033-666
PLACE OF BIRTH

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison
City of Rexburg

CERTIFICATE OF BIRTH **148915**

No. St. Registration District No. 100 State File No.

Hospital Primary Registration District No. 2178 Local Registrar's No. 2

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? } and { Number in order of birth Legitimate? Yes Date of Jan 23 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Emm Andrew Beerley
RESIDENCE Rexburg
COLOR white AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE Utah
OCCUPATION Grain & Produce merchant

MOTHER
FULL MAIDEN NAME Grove Woodmansee
RESIDENCE Rexburg
COLOR white AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4 P M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Louis J. Rish

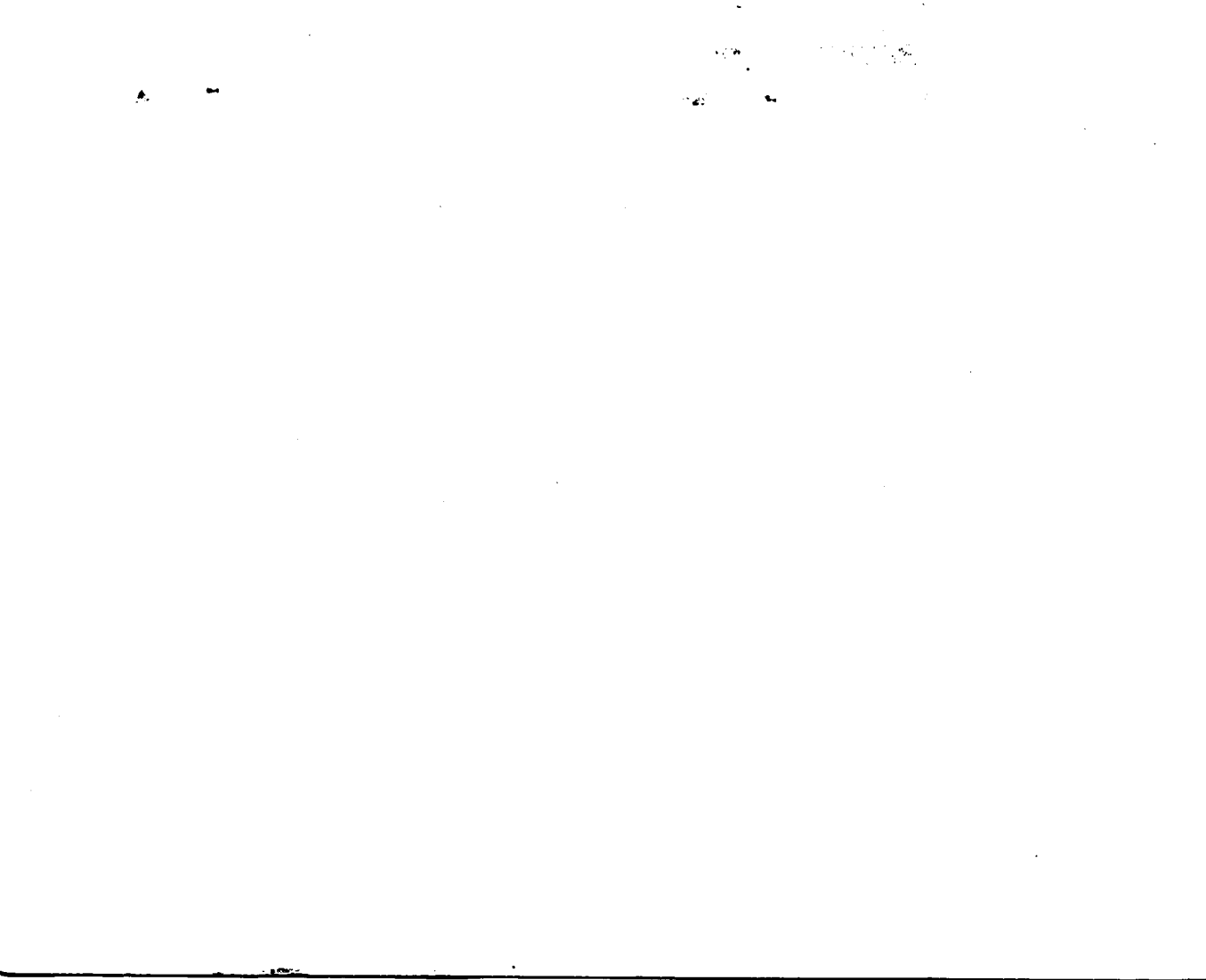
(Physician or midwife)

Address Rexburg Idaho

Filed 1/24 1927

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19

1. PLACE OF DEATH

County of Madison.

City of Rexburg.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Beesley

Registration District No. 100

Primary Registration District No. 2178

(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 56656

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Infant.

(Write the word)

6. DATE OF BIRTH

Jan 23 1927
(Month) (Day) (Year)

7. AGE

- Yrs. - Mos. - ds. -

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Rexburg, Idaho.

10. NAME OF

Father Emer Andrew Beesley.

11. BIRTHPLACE

OF FATHER

(State or Country) Utah.

12. MAIDEN NAME

OF MOTHER

Grace Woodmanse.

13. BIRTHPLACE

OF MOTHER

(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emer Andrew Beesley.

(Address) Rexburg, Idaho.

15.

Filed 1/24/ 1927

J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 23 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1927, to Jan 27 1927, that I last saw him at Jan 27 1927, and that death occurred on the date stated above, at - M.

The CAUSE OF DEATH* was as follows

Unassisted foetus
(stillborn)

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Strangled knot of cord
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
2. (Signed) John A. Rich M. D.
1927 (Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sugar City Cem.

DATE OF BURIAL

1/24/27 1927

20. UNDERTAKER

ADDRESS

Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

619-108.034-331
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 148936

County of Mindaco
City of Rupert Idaho
No. _____ St. _____ Registration District No. 19 State File No. _____
Hospital _____ Primary Registration District No. 2013 Local Registrar's No. 10

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth 1-8-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME

Herman Peter Fails

RESIDENCE Rupert Idaho

COLOR White AGE AT LAST BIRTHDAY 43
(Years)

BIRTHPLACE Ohio

OCCUPATION Cream Buyer

MOTHER
FULL MAIDEN NAME

Mable Clark

RESIDENCE Rupert Idaho

COLOR White AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{Dead alive} at 10:10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Leona Fager M.D.

(Physician or midwife)

Address

Rupert, Idaho

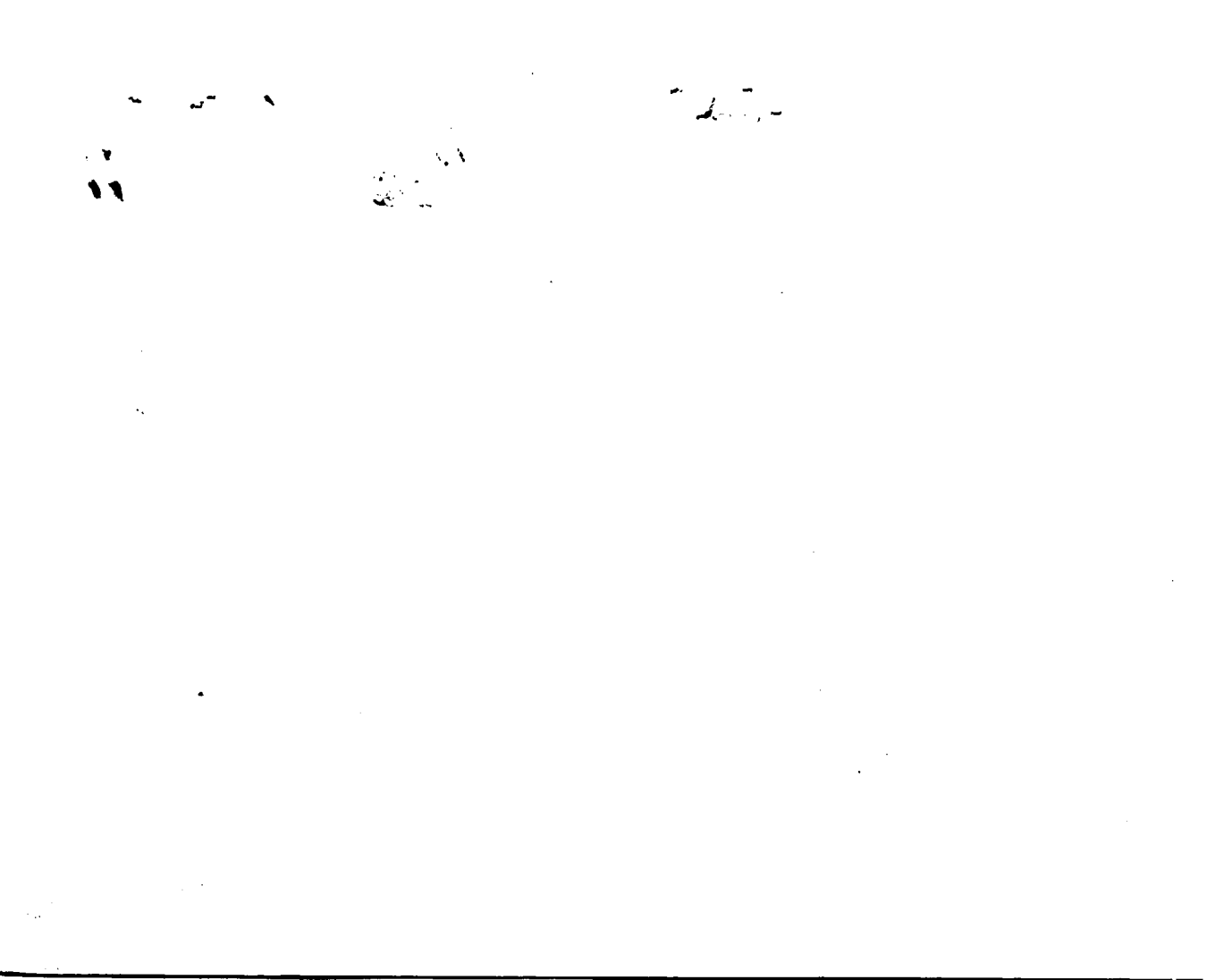
Filed

1-31 1927

E. E. Elmore

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 10 1927 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59024

Local Registrar's No. 41

PLACE OF DEATH

County of Minedoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Falls

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Jan 8 1927 Still Born

7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Rupert
(State or country) Minedoka Co Ida

10 NAME OF FATHER Herman P Falls

11 BIRTHPLACE OF FATHER (city or town) Iowa Ohio
(State or country)

12 MAIDEN NAME OF MOTHER Mable Clark

13 BIRTHPLACE OF MOTHER (city or town) Ogden Weber Co Wt.
(State or country)

14 Informant Jos. Payne
(Address) Paul Ida

15 Filed Oct 13 1927 E. E. Moore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That, I attended deceased from Jan 8, 1927, to Jan 8, 1927, that I last saw h. _____ alive on her alive, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Stillborn Child

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Deland F. Jones, M. D.

_____, 19____ (Address) Rupert, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Rupert Ida Date of Burial 1-9 1927

20. Undertaker W. E. Johnson Address Barley Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

314-229035-812
PLACE OF BIRTH

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

148994

County of Nez Perce

City of Lewiston

No. _____ St. _____

Registration District No. 96

File No. _____

Hospital St. Joseph

Primary Registration District No. 1009

Registered No. _____

FULL NAME OF CHILD Stillborn, Lamphier

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Jan. 29</u> 192 <u>7</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? 2% Silver Nitrate

Number of child of this mother, including present birth 2nd Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Fred Dale Lamphier
RESIDENCE Genesee, Idaho
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Idaho
OCCUPATION mechanic

MOTHER
FULL MAIDEN NAME Veronica Harpurther
RESIDENCE Genesee, Idaho
COLOR white AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Jan. 29 at 9 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Paul D. Huser

(Physician or midwife)

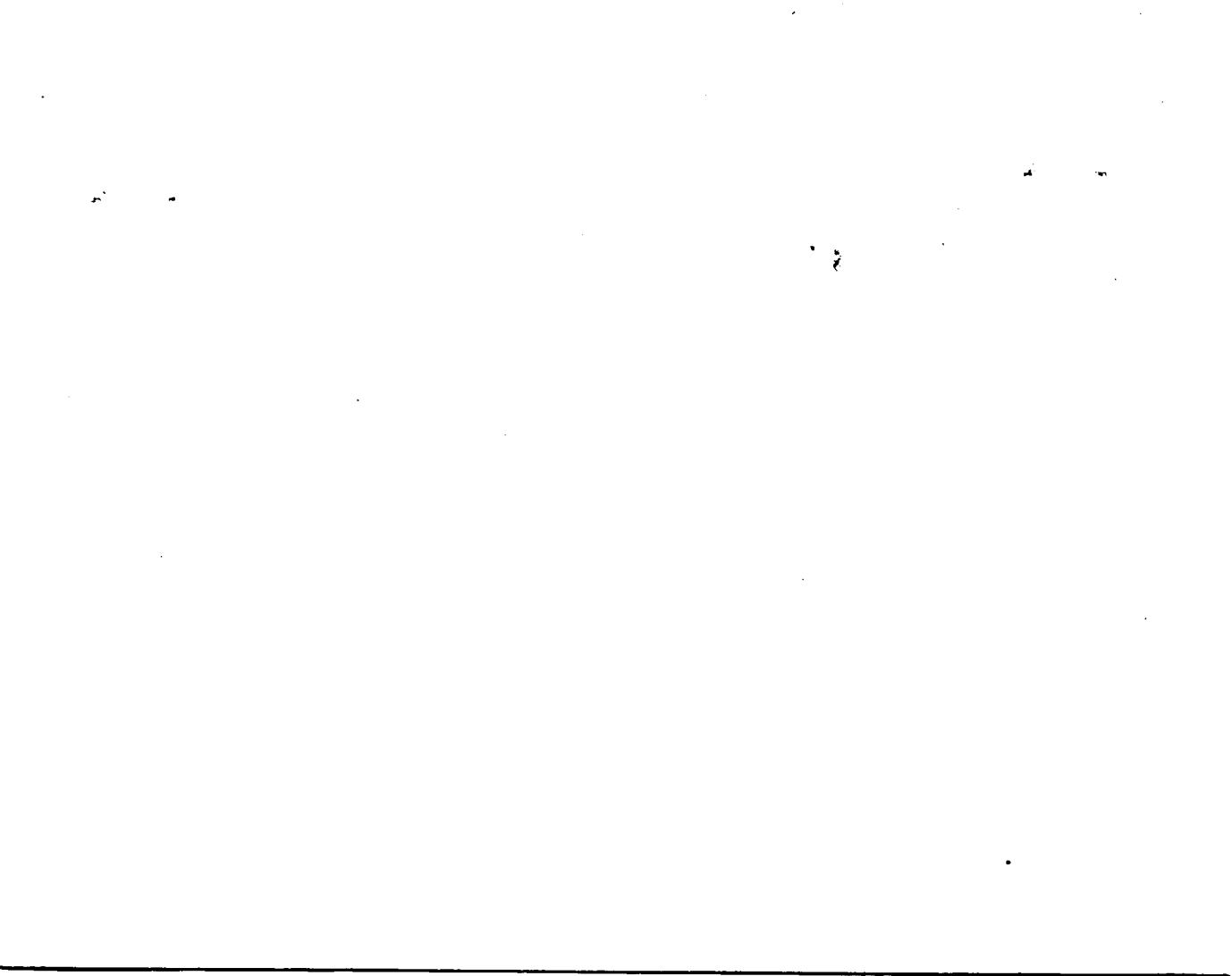
Give names added from a supplemental report.

Address Lewiston, Idaho

Filed 2-10 1927

Doran E Bruce
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **56377**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Benewah
City of Lewiston

Registration District No. 26
Primary Registration District No. 1409
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Laughier

(a) Residence. No. _____ St. Benewah, Idaho

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

16 DATE OF DEATH Jan 29 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1926, to Jan 29, 1927.

6 DATE OF BIRTH (month, day and year)

that I last saw h. _____ alive on _____, 19____.

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

and that death occurred, on the date stated above, at _____ m.

8 OCCUPATION OF DECEASED

THE CAUSE OF DEATH* was as follows:

(a) Trade, profession, or particular kind of work. None

Still born - had probably been dead one month. The mother had albumenuria.

(b) General nature of industry, business, or establishment in which employed (or employer)

(duration) _____ yrs. _____ mos. _____ ds.

(c) Name of employer

CONTRIBUTORY (Secondary)

9 BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER J. D. Laughier

Did an operation precede death? no Date of _____

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country) Idaho

Was there an autopsy? no

What test confirmed diagnosis? none

12 MAIDEN NAME OF MOTHER Phrony Harpather

(Signed) Paul W. Johnson M. D.

1/29 1927 (Address) Lewiston Idaho

13 BIRTHPLACE OF MOTHER (city or town) Benewah
(State or country) Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant Mrs. Geo Carbur
(Address) Lewiston Idaho

19 Place of Burial, Cremation, or Removal Benewah, Idaho
Date of Burial 19____

15 Filed 2-11- 1927 Russ E Bruce
Registrar

20. Undertaker Brooks - Wain & Address Lewiston Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695-148-035-291
PLACE OF BIRTH RECEIVED FEB 1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 149004

County of Blaine
City of Albion
No. _____ St. Registration District No. 96 State File No. _____
Hospital St. Joseph's Primary Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD Edward Freeman Jr
(Certificate of no value without full name of child)

Sex of Child M. Twin X Triplet or other? X and { Number in order of birth } Legitimate? Yes Date of birth Jan 10 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER FULL NAME <u>Edward Harding Freeman</u> RESIDENCE <u>201 Springs Mont.</u> COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>30</u> (Years) BIRTHPLACE <u>Wis.</u> OCCUPATION <u>Saw mill man</u>		MOTHER FULL MAIDEN NAME <u>Ernesta Ruth Bradshaw</u> RESIDENCE <u>201 Springs Mont.</u> COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>21</u> (Years) BIRTHPLACE <u>Mont.</u> OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

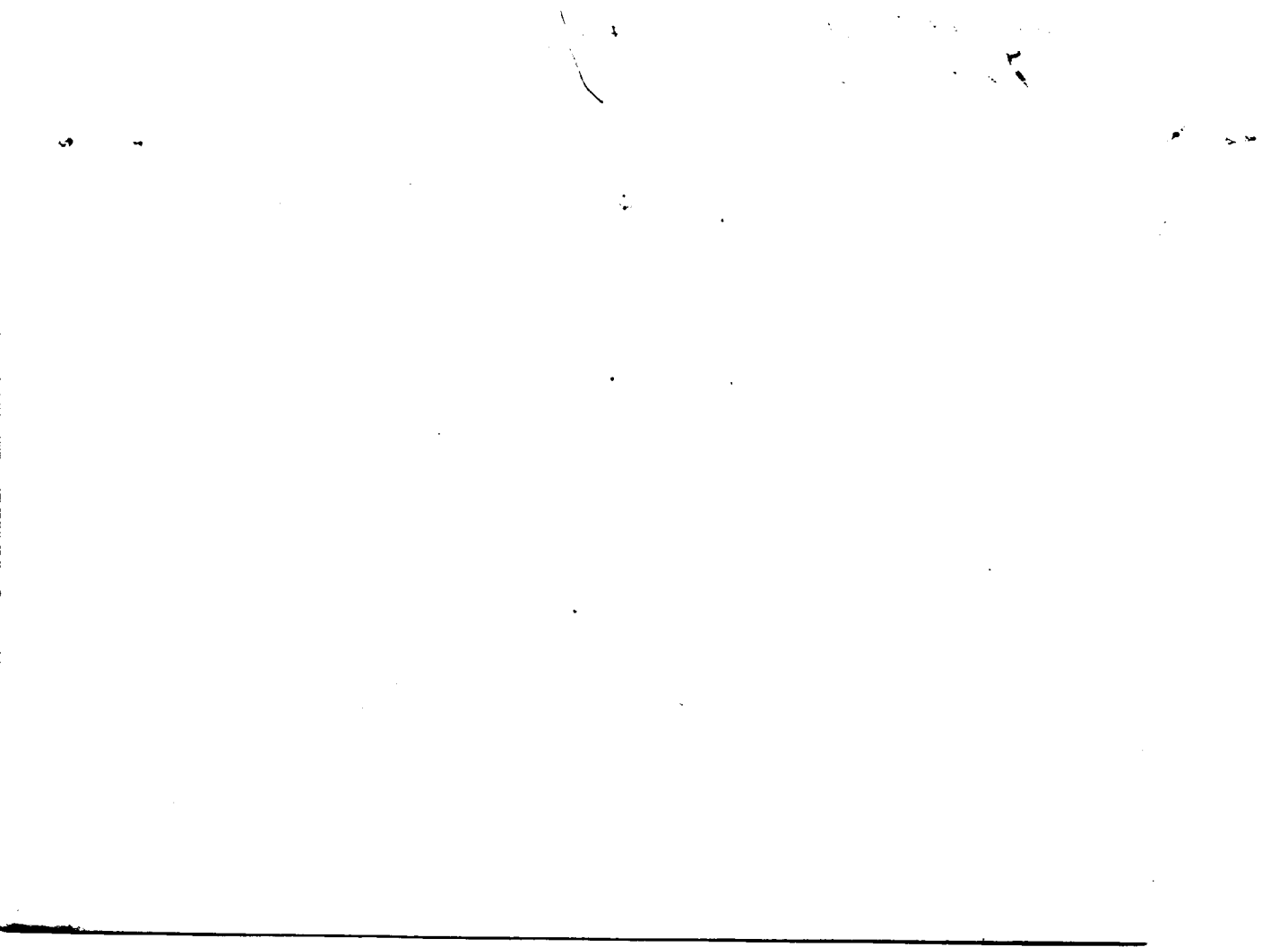
I hereby certify that I attended the birth of this child, who was born alive at Albion Ida on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Blaine
(Physician or midwife)

Address Albion Ida

Filed 2-10-1927 Dwain E Bruce
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **56369**

PLACE OF DEATH

CERTIFICATE OF DEATH

Local Registrar's No. _____

County of Nezperce
City of Lewiston

Registration District No. 76
Primary Registration District No. 1009
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Freeman Jr.

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Premature

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)

10 NAME OF FATHER Edward Freeman
11 BIRTHPLACE OF FATHER (city or town) Minnesota
(State or country)
12 MAIDEN NAME OF MOTHER Cerilla Bradshaw
13 BIRTHPLACE OF MOTHER (city or town) Philipsburg, Mont.
(State or country)

14 Informant Edward Freeman
(Address) Lewiston, Ida.

15 Filed 2-11-27 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 10 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Jan 10, 1927, at Lewiston, Ida.
that I last saw him alive on Jan 10, 1927,
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Suicide

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Unknown

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? Yes Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. H. R. Merchant M. D.
1/14, 1927 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal 1. 13/27 Clarkston Wn Date of Burial 1/13/27 19

20. Undertaker H. R. Merchant Address Clarkston Wn

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

- Enter date of filing on the certificate immediately and
- give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

365-110-003-434
PLACE OF BIRTH
RECEIVED FEB 19 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
149283

County of Bannock

City of Pocatello

No. 430203rd St.

Registration District No. 28

File No. 149283

Hospital

Primary Registration District No. 2161 Registered No. 7961

FULL NAME OF CHILD Not named Still Born (premature)
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth... <u>2-10</u> ...192 <u>7</u> (Month) (Day) (Year)
-----------------------------	---	-----	--------------------------------	--------------------------------	---

What bacteriocidal solution was used in eyes? Still Born (premature)

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER
FULL NAME Nicholas Cantaras
RESIDENCE 430 203rd
COLOR white
AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Mexico
OCCUPATION A.S. Line R.R.

MOTHER
FULL MAIDEN NAME Lillian McMahon
RESIDENCE 430 203rd
COLOR white
AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Pocatello, Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born at 5:20 a.m.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Brown
(Physician or midwife)

Give names added from a supplemental report.
....., 19.....
Registrar.

Address 14020 Johnson
Filed 2/1 1927 Registrar.

11-11-11

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

RECEIVED MAR 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56793

County of Bannock
City of Paris

Registration District No. 28

Primary Registration District No. 34

Local Registrar's No. 4790

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Contreras

(a) Residence. No. 430 N. 2 St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Chief

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 10 1927

7 AGE Still Born Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho
(State or country)

10 NAME OF FATHER Nick Contreras

11 BIRTHPLACE OF FATHER (city or town) Mexico
(State or country)

12 MAIDEN NAME OF MOTHER Lucia M. Mahon

13 BIRTHPLACE OF MOTHER (city or town) Boonville Id
(State or country)

14 Informant Nick Contreras
(Address) Boonville Idaho

15 Filled 2-11, 1927 W. J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 10 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1927, to Feb 10, 1927

that I last saw her dead on Feb 10, 1927

and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Still Born

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Still Born

(Signed) W. J. Young, M. D.

710727 1927 (Address) Boonville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Date of Burial Feb 11 1927

20. Undertaker Schumacher & Hall Address Craig

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

849-112-006-168
PLACE OF BIRTH

RECEIVED

MAR 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

149334

County of Bingham

City of Blackfoot

No. St. Registration District No. 171 State File No.

Hospital Primary Registration District No. 1007 Local Registrar's No. 68

FULL NAME OF CHILD Stillborn Hurst

(Certificate of no value without full name of child)

Sex of Child Male Twin Tripled or other? and { Number in order of birth } Legitimate? Yes Date of birth Feb 17 192 7
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Clarence M. Hurst
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Kansas
OCCUPATION Teacher

MOTHER
FULL MAIDEN NAME Eva M. Johnson
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Nebraska
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn Non-viable at 8:30 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192

(Signature) W. W. Beck

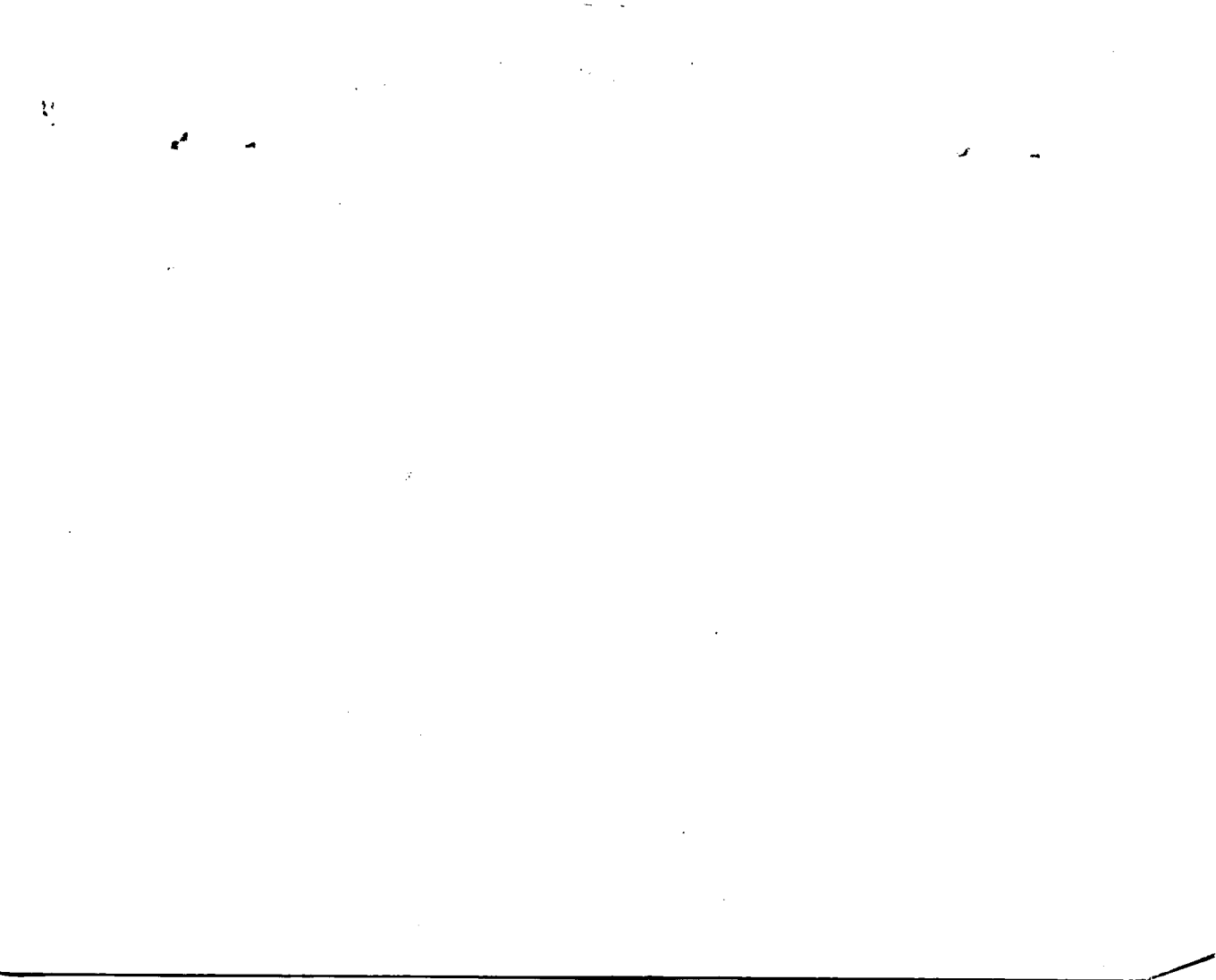
(Physician or midwife)

Address Blackfoot, Idaho

Filed Mar. 5 192 7 Mrs. Helen E. Hattie

Registrar.

Registrar.



FORM V. S. N. 5-25 M. 1-19.

1.

PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single

(Write the word)

6. DATE OF BIRTH

February

12

1927

(Month)

(Day)

(Year)

7. AGE

Stillborn

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clarence M. Hurst

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Eva M. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence M. Hurst

(Address)

59 No. Spruce St.

15.

Filed

Feb-14

1927

M. Under E. J.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

12

1927

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 12 1927 to Feb 12 1927,
that I last saw him alive on Feb 12 1927,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Asphyxia from prolapsed cord

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. T. Beck M. D.

2/12/1927 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burial City Cemetery 2-18-1927

Local Registrar

ADDRESS

Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

201-009-168
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED MAR 7 1927

CERTIFICATE OF BIRTH

149357

County of Bonne
City of Sandpoint
No. _____ St. Registration District No. 78 State File No. _____
Hospital Parnell Primary Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD (stillborn) Washburn

(Certificate of no value without full name of child)

Sex of Child Female { Twin } and { Number } Legiti- Date of
Triplet in order mate Yes. birth Feb. 1 1927
or other? of birth (Month) (Day) (Year)
(To be answered only in event of plural births)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
	<u>Chas Alexander Washburn</u>		<u>Hellie Jay Johnson</u>
RESIDENCE	<u>Colburn, Idaho</u>	RESIDENCE	<u>Colburn, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
	AGE AT LAST BIRTHDAY <u>45</u> (Years)		AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE	<u>Portland, Michigan</u>	BIRTHPLACE	<u>Woodfield, Wisconsin</u>
OCCUPATION	<u>Logger</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 P. M. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Floyd M. Jones
M. D.
(Physician or midwife)

Address Sandpoint, Ida.

Filed March 4 1927 Viola Allen
Deputy Registrar.

Registrar.

SECRET

SECRET

SECRET

SECRET

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56545

PLACE OF DEATH
County of Donner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Washburn

(a) Residence. No. _____ St.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 1, 1927

7 AGE Years Stillbirth Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho.

10 NAME OF FATHER Chas. Washburn

11 BIRTHPLACE OF FATHER (city or town) Michigan
(State or country)

12 MAIDEN NAME OF MOTHER Nellie M. Johnson

13 BIRTHPLACE OF MOTHER (city or town) Woodville
(State or country) Miss

14 Informant Chas. A. Washburn
(Address) Colburn, Idaho.

15 Filled Feb 3, 1927 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stillbirth 19_____
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19_____, to _____, 19_____,
that I last saw h. _____ alive on _____, 19_____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillbirth
for depts delivery
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Wendt, M. D.
Feb. 3, 1927 (Address) Sandpoint
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lakeview Cemetery Date of Burial Feb. 4 1927

20 Undertaker L. H. Moon Address Sandpoint, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

363-1251009-157
PLACE OF BIRTH

RECEIVED MAR 7 1033

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

149360

County of Bonner
City of Sandpoint
No. _____ St. Registration District No. 78 State File No. 149360
Hospital Ragle Primary Registration District No. 9155 Local Registrar's No. _____
FULL NAME OF CHILD William Randolph Colomb Jr.
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? 2 and { Number in order of birth 1 Legitimate? yes Date of birth 2-25-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? —

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>William Randolph Colomb</u>	<u>Sandpoint</u>	<u>Bessie Lorain Jeppeson</u>	<u>Sandpoint</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Oregon</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>labor</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

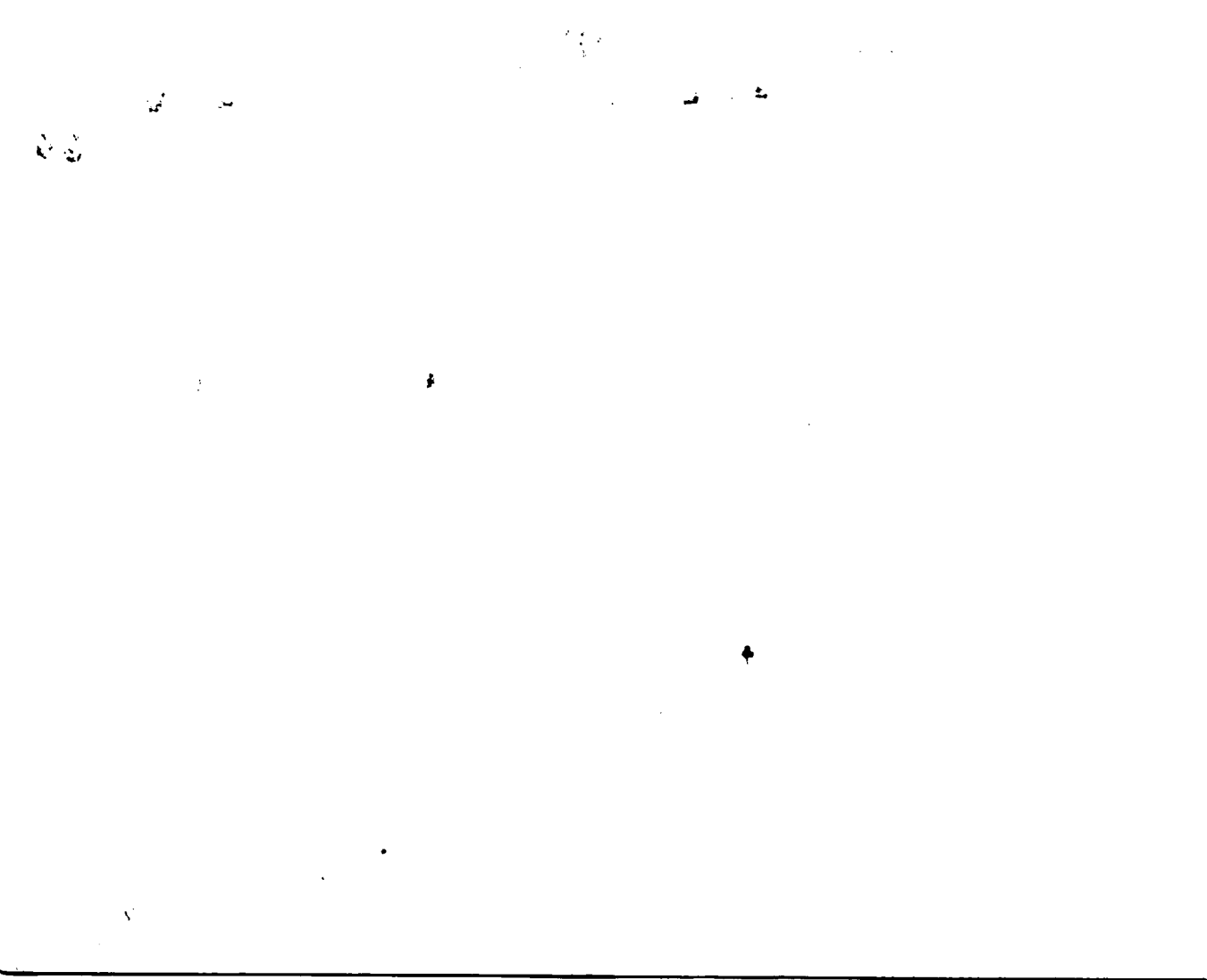
I hereby certify that I attended the birth of this child, who was { Dead alive } at 9:30 M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. D. [Signature]
(Physician or midwife)

Address Sandpoint Idaho
Filed March 4 1927 Viola Allen
Deputy Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 7 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 56549

County of Bonner
City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (Shelburn) Colomb

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 25, 1926

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10 NAME OF FATHER William Colomb

11 BIRTHPLACE OF FATHER (city or town) Perry
(State or country) Oregon

12 MAIDEN NAME OF MOTHER Bessie Jeppson

13 BIRTHPLACE OF MOTHER (city or town) Bancroft
(State or country) Idaho

14 Informant William Colomb
(Address) Sandpoint Idaho

15 Filed Feb. 27, 1927 Viola Allen
deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 25, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1927, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Instrumental injury
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. W. Allen
2-25-27 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Pinecrest Cemetery Date of Burial Feb. 27, 1927

20. Undertaker L. H. Moon Address Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton Mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Carcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

74-117-089-445
PLACE OF BIRTH RECEIVED MAR 9 1927 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Bonner
City of Priest River
CERTIFICATE OF BIRTH 149369
No. _____ St. _____ Registration District No. 85 State File No. 12
Hospital _____ Primary Registration District No. 2185 Local Registrar's No. 10
FULL NAME OF CHILD Patrick Gumaer
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Feb. 17</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>5</u>		Number of child of this mother now living, including present birth <u>4</u>	
FATHER FULL NAME <u>Fred Gumaer</u> RESIDENCE <u>Priest River</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>46</u> (Years) BIRTHPLACE <u>Wisconsin</u> OCCUPATION <u>Mechanic</u>		MOTHER FULL MAIDEN NAME <u>Eara Hume</u> RESIDENCE <u>Priest River</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>37</u> (Years) BIRTHPLACE <u>Wash</u> OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10 A.M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

E. E. Getloff M.D.

(Physician or midwife)

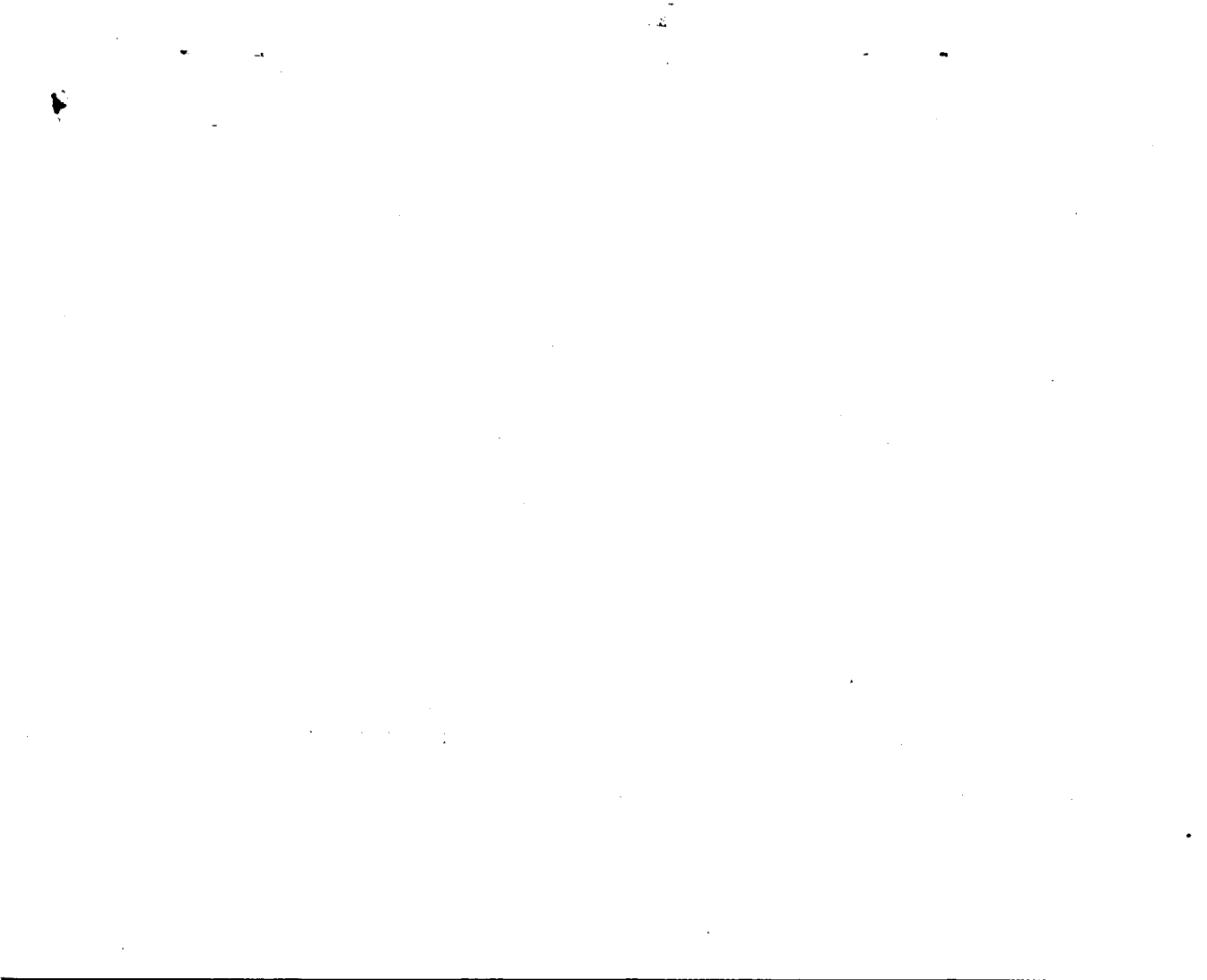
Address

Priest River, Id.

Filed

March 1, 1927 E. E. Getloff Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGB should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-25 M. 1-19.

RECEIVED MAR 9 1927

CERTIFICATE OF DEATH

56540

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bonner
City of Priest River

Registration District No. 80
Primary Registration District No. 2180
(No. _____ St.)

File No. _____
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Gumaer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH Feb. 17 1927
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
how many _____ hrs.
Yrs. _____ Mos. _____ ds. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Priest River Idaho
(State or Country)

10. NAME OF FATHER Fred Gumaer

11. BIRTHPLACE OF FATHER Wisconsin
(State or Country)

12. MAIDEN NAME OF MOTHER Cora Dunn

13. BIRTHPLACE OF MOTHER Washington
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Gumaer
(Address) Priest River

15. Filed Mar 1 1927 E. E. Getloff
Local Registrar

16. DATE OF DEATH Feb. 17 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1927, to Feb. 17 1927, that I last saw him alive on Feb. 17 1927, and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:
Placenta previa
premature six months

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Getloff M. D.

Feb. 17 1927 (Address) Priest River Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Priest River DATE OF BURIAL Feb. 17 1927

20. UNDERTAKER Fred Gumaer ADDRESS Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

632-201-010-154
PLACE OF BIRTH

RECEIVED FEB 18 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH

149379

No. _____ St. _____ Registration District No. 73 State File No. _____

Hospital _____ Primary Registration District No. 2120 Local Registrar's No. 6

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? x and { Number in order of birth _____ } Legitimate? yes Date of birth 1 1 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Harold Olsen
RESIDENCE Idaho Falls
COLOR W. AGE AT LAST BIRTHDAY 25
(Years)
BIRTHPLACE Utah
OCCUPATION Labourer

MOTHER
FULL MAIDEN NAME Victoria Anderson
RESIDENCE Idaho Falls
COLOR W. AGE AT LAST BIRTHDAY 21
(Years)
BIRTHPLACE Idaho Falls
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7 40 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

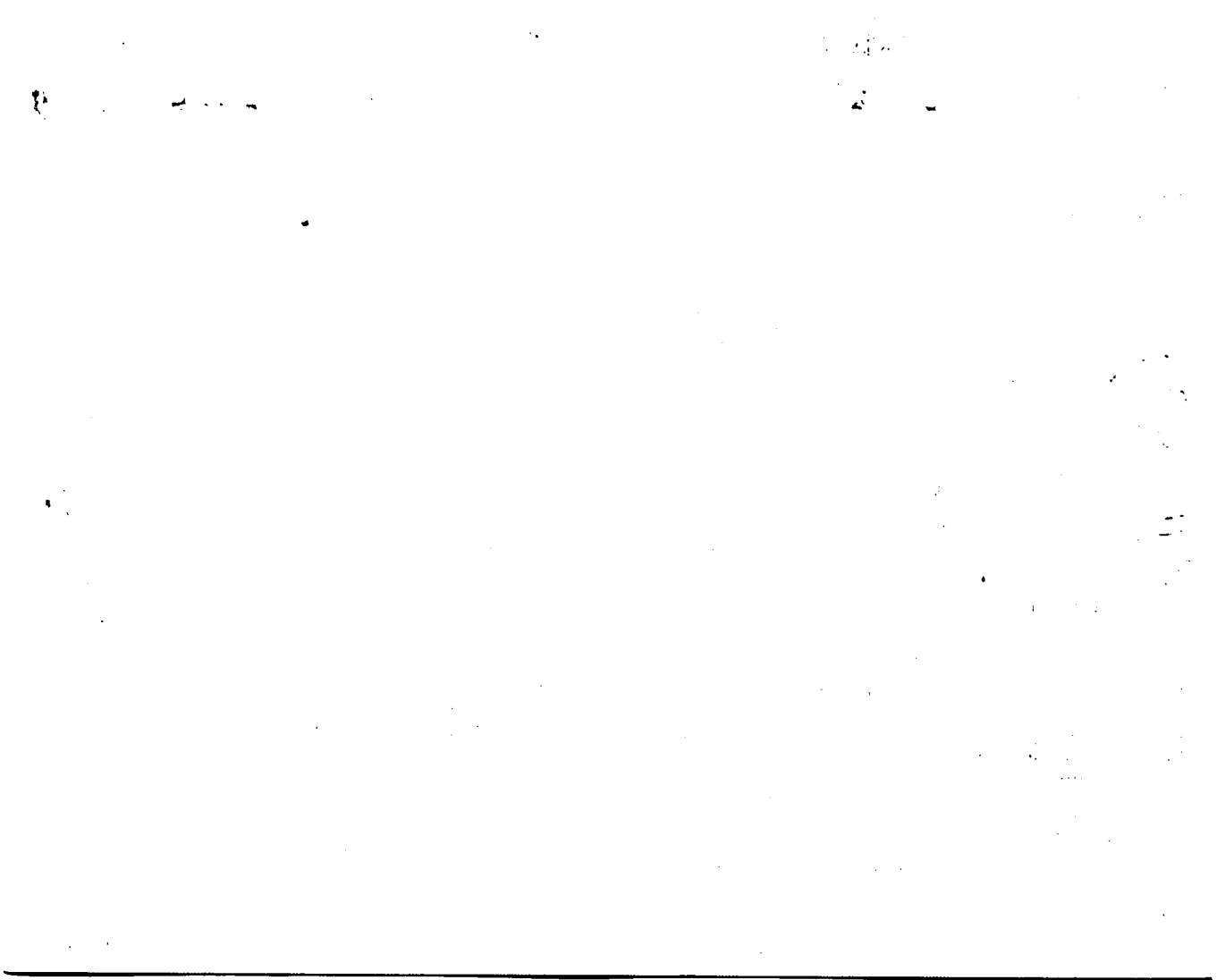
(Physician or midwife)

Address 224 East Bldg. Ide Falls

Filed 1927 Confirman

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 18 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **56550**

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 23
Primary Registration District No. 23
(No. _____)

Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born

(a) Residence. No. 202 Chamberlain St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) and single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Baby

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min. Still born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Still born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls
(State or country)

10 NAME OF FATHER Harold Olsen

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Victoria Anderson

13 BIRTHPLACE OF MOTHER (city or town) Idaho Falls
(State or country)

14 Informant Harold Olsen
(Address) 202 Chamberlain Idaho Falls

15 Filled Jan 3 1927 Confinement
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 1 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/1/27, 19____, to 1/1/27, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Hard Labor
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. Blanton, M. D.
1/1/27, 19____ (Address) 224 East 13th
Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Idaho Falls Idaho 1/3 1927
20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED FEB 18 1927		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
433-22-10-434				CERTIFICATE OF BIRTH		149399	
County of <u>Idaho</u>		City of <u>Idaho Falls</u>		No. <u>73</u> St. Registration District No. <u>2 N-2</u>		State File No. <u>41</u>	
Hospital <u>L. D. S.</u>		Primary Registration District No. <u>2 N-2</u>		Local Registrar's No. <u>41</u>			
FULL NAME OF CHILD <u>Steele</u>		(Certificate of no value without full name of child)					
Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>1-24</u> <u>1927</u>		(Month) (Day) (Year)		
What bactericidal solution was used in eyes? <u> </u>							
Number of child of this mother, including present birth <u>2</u>				Number of child of this mother now living, including present birth <u>2</u>			
FATHER				MOTHER			
FULL NAME <u>Herbert V Mc Cauley</u>				FULL MAIDEN NAME <u>Jane Mc Mc Massey</u>			
RESIDENCE <u>Thomas Idaho</u>				RESIDENCE <u>Thomas Idaho</u>			
COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>51</u> (Years)		COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>25</u> (Years)	
BIRTHPLACE <u>Wisconsin</u>				BIRTHPLACE <u>Idaho</u>			
OCCUPATION <u>Farmer</u>				OCCUPATION <u>Housewife</u>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*							
I hereby certify that I attended the birth of this child, who was <u>born alive</u> <u>Stillborn</u> at <u>8</u> <u>12</u> <u>3</u> M. on the date above stated.							
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.							
Give names added from a supplemental report. <u> </u> , 192 <u> </u>							
Registrar. <u> </u>				Address <u>Idaho Falls Idaho</u>			
Filed <u>112</u> 192 <u>7</u>				Registrar. <u> </u>			



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238-125-223-843
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Sanborn RECEIVED MAR 9 1927
CITY OF Emmett CERTIFICATE OF BIRTH 149574
No. _____ St. Registration District No. 4 State File No. _____
Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD George Calvin Schneconyon
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth 3-5- 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5
FATHER FULL NAME George Calvin Schneconyon MOTHER FULL MAIDEN NAME Godely May Hull
RESIDENCE Emmett RESIDENCE Emmett
COLOR or AGE AT LAST BIRTHDAY 36 (Years) COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Idaho BIRTHPLACE Oklahoma
OCCUPATION Farmer OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

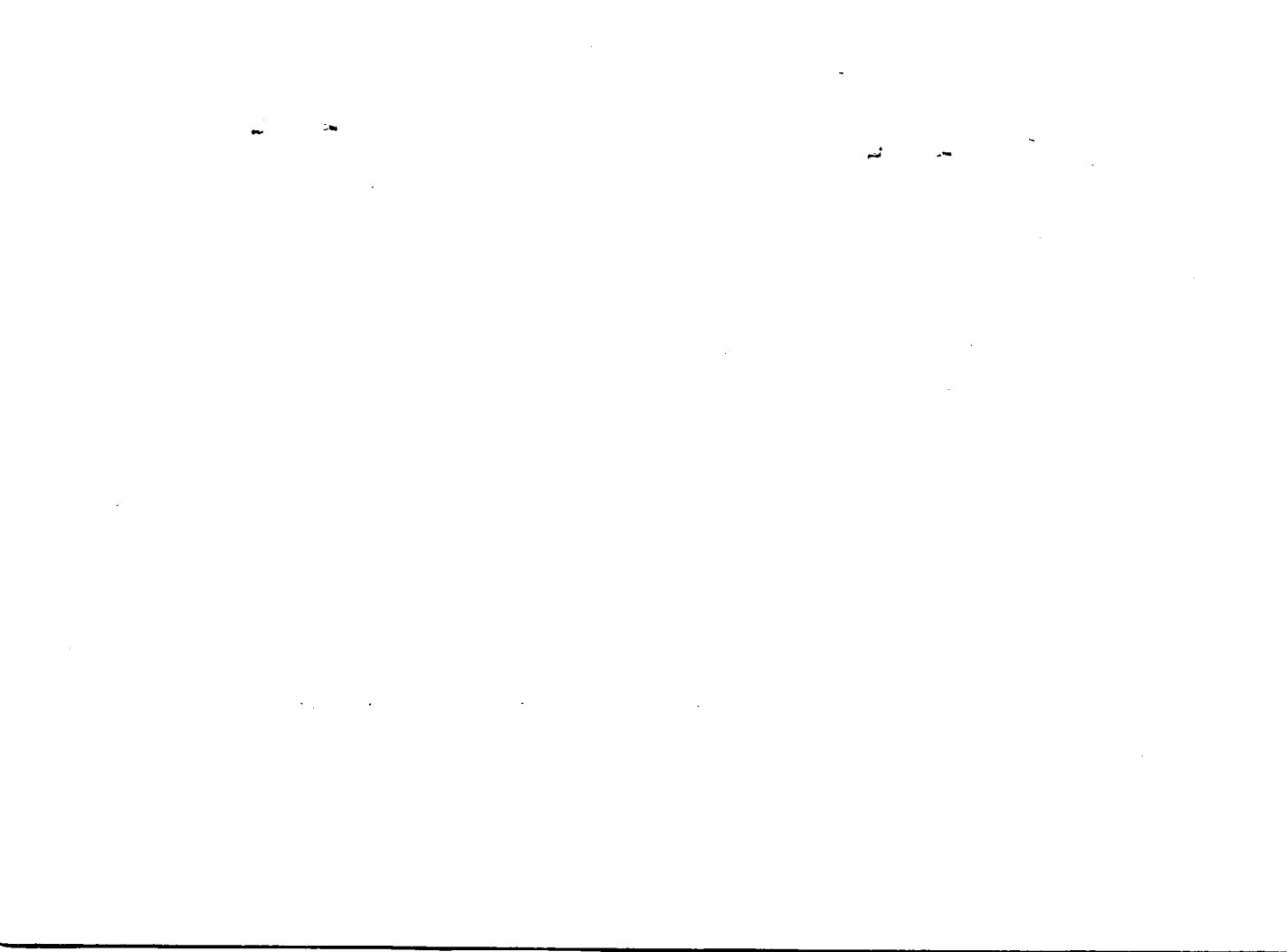
I hereby certify that I attended the birth of this child, who was { Stillborn } at 9-30 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) J. L. Reynolds
(Physician or midwife)

Address Emmett
Filed 9-5- 1927 J. L. Reynolds Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **56618**

1. PLACE OF DEATH

Registration District No. **6**
County of **Idaho** Primary Registration District No. **6**
City of **Emmett** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Infant**
(Write the word.)

6. DATE OF BIRTH

2-5-27
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. da. or min. ? IF LESS than 1 day how many hrs.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

George Calvin Schrecongost

11. BIRTHPLACE OF FATHER

(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER

Sallie Hull

13. BIRTHPLACE OF MOTHER

(State or Country) **Oklahoma**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Geo. Schrecongost**(Address) **Emmett**

15.

Filed **19** **26**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3-5-25
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____

that I last saw **at birth** alive on 19____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

detached Placenta, and hemorrhage

(Duration) Yrs. ____ Mos. ____ Da. ____

Contributory (Secondary) **maternal infarct**

(Duration) Yrs. ____ Mos. ____ Da. ____

(Signed) **J. H. Reynolds** M. D.19____ (Address) **Emmett**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. ____ Mos. ____ Days ____ In the State Yrs. ____ Mos. ____ Days ____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emmett **7/6** 19**26**

20. UNDERTAKER ADDRESS

Emmett

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED MAR 7 1927
City of *A. F. D. Rupert*

CERTIFICATE OF BIRTH

149703

No. St. Registration District No. *19* State File No.
Hospital Primary Registration District No. *2015* Local Registrar's No. *35*

FULL NAME OF CHILD *Unmarried*
(Certificate of no value without full name of child)

Sex of Child *Female* Twin Triplet or other? } and { Number in order of birth } Legitimated *no* Date of birth *Feb 11* 192*7*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *2* Number of child of this mother now living, including present birth *1*

FATHER
FULL NAME *Refused to tell*
RESIDENCE
COLOR AGED AT LAST BIRTHDAY (Years)
BIRTHPLACE
OCCUPATION

MOTHER
FULL MAIDEN NAME *Bertha Myggie Polson*
RESIDENCE *Rupert, Idaho*
COLOR *White* AGE AT LAST BIRTHDAY *26* (Years)
BIRTHPLACE *Missouri*
OCCUPATION *Housework*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was *born alive* Stillborn { at *4:00 a.* M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

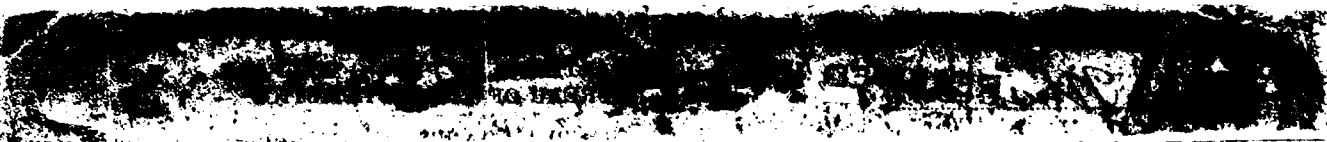
Give names added from a supplemental report.
....., 192*7*

(Signature) *Leland Frazier M.D.*

(Physician or midwife)

Address *Rupert Idaho*

Filed *3-5* 192*7* *L. E. Elmer*
Registrar. Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

56662

State File No.

Local Registrar's No.

PLACE OF DEATH

County of Minedoka
City of Paul

Registration District No. 19

Primary Registration District No. 2013

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Pollard

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Feb. 11, 1927

6 DATE OF BIRTH (month, day and year) Feb. 11, 1927

7 AGE Years Months Days 1 day, _____ hrs. or _____ min. Still Birth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Paul
(State or country) Minedoka Co Idaho

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Bertha M Pollard

13 BIRTHPLACE OF MOTHER (city or town) Long View Missouri
(State or country)

14 Informant R. E. Stockton
(Address) Paul Idaho

15 Filled 2-11, 1927 E. E. Emme
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 11 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1927, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn child

CONTRIBUTORY (Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirms diagnosis? _____
(Signed) Edmund Fryer, M. D.
_____ 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Burley Ida Date of Burial Feb 12 1927

20. Undertaker W. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

636-225-035-177
PLACE OF BIRTH

RECEIVED MAR 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 149730

County of Nezperce
City of Lewiston
No. 1 St. Registration District No. 96 File No. 1
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. 7
FULL NAME OF CHILD Stillborn Flock
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>no</u>	{ and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Feb 25</u> 192 <u>7</u> (Month) (Day) (Year)
----------------------------	----------------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 3rd Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Tiffany Mindon Flock</u>	FULL MAIDEN NAME	<u>Maida Appleford</u>
RESIDENCE	<u>Anatone, Washington</u>	RESIDENCE	<u>Anatone, Washington</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY <u>28</u> (Years)		AGE AT LAST BIRTHDAY <u>27</u> (Years)	
BIRTHPLACE	<u>Washington</u>	BIRTHPLACE	<u>Washington</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 p. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Paul W. Johnson
(Physician or midwife)

Give names added from a supplemental report.

Address

Lewiston, Idaho

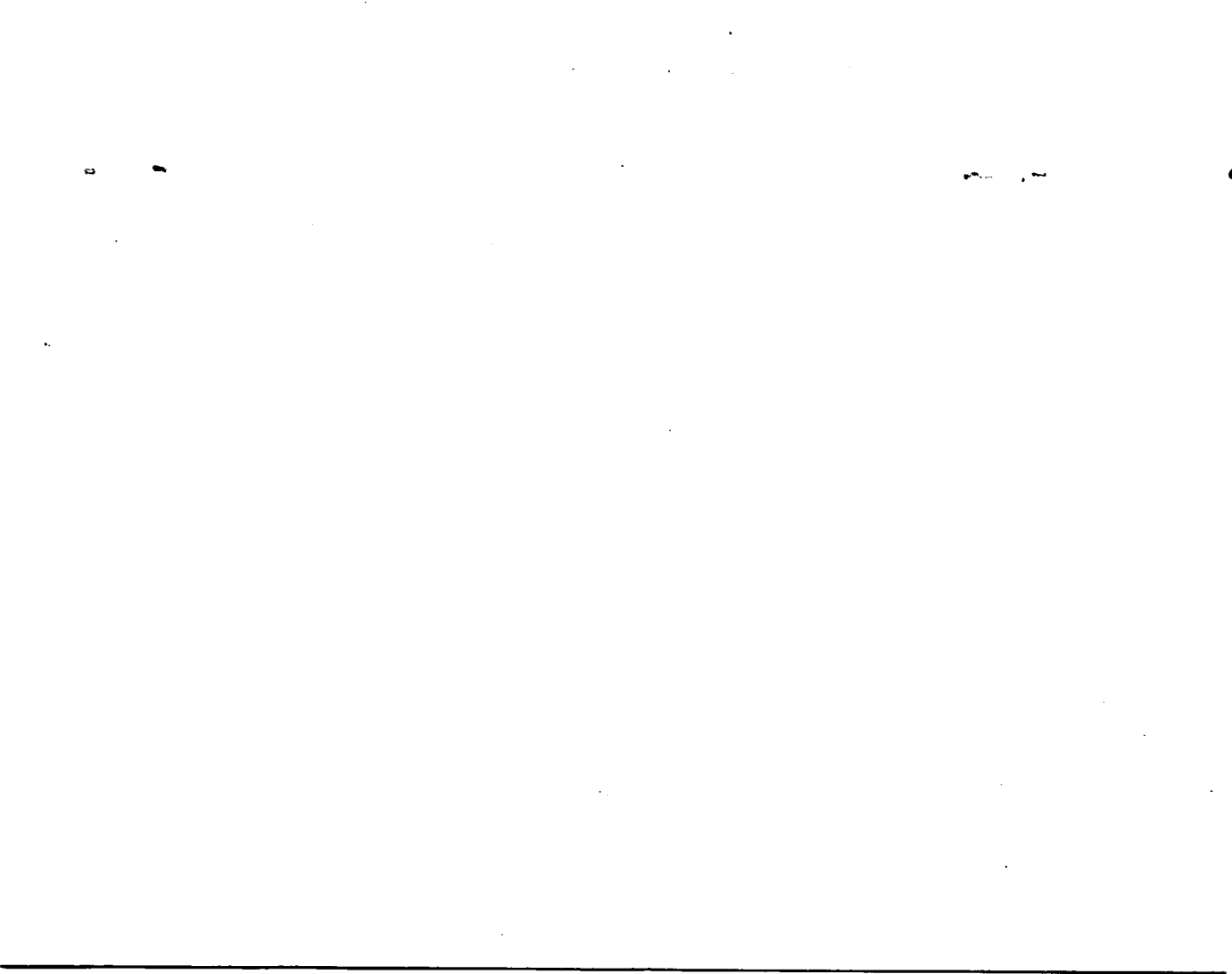
Filed

Mar 9 1927

Susan E. Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 56675

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis Fern Flock

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____

16 DATE OF DEATH Feb 25 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to Feb 25, 1927, that I last saw her alive on still born, 19____, and that death occurred, on the date stated above, at ____ m.

6 DATE OF BIRTH (month, day and year) Feb. 25, 1927
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, ____ hrs. or ____ min.

The CAUSE OF DEATH* was as follows:
Still born, been dead in utero about one week. mother had influenza.
(duration) ____ yrs. ____ mos. ____ ds.

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTORY (Secondary) _____ (duration) ____ yrs. ____ mos. ____ ds.

9 BIRTHPLACE (city or town) Lewiston, Ida.
(State or country)

18 Where was disease contracted If not at place of death? _____

10 NAME OF FATHER M. T. Flock

Did an operation precede death? no Date of _____

11 BIRTHPLACE OF FATHER (city or town) Anatone, Wash
(State or country)

Was there an autopsy? no

What test confirmed diagnosis? none
(Signed) Paul W. H. Mearns M. D.
2/26, 1927 (Address) Clarkston

12 MAIDEN NAME OF MOTHER Maida A Appleford

13 BIRTHPLACE OF MOTHER (city or town) Asotin, Wash.
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 Informant M. T. Flock
(Address) Anatone Wash

19 Place of Burial, Cremation, or Removal Clarkston, Wash Date of Burial 2/26/27 19____

15 Filed Mar 9, 1927 Dean E Bruce
Registrar

20. Undertaker H. R. Mearns Address Clarkston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

249-224035-255
PLACE OF BIRTH

RECEIVED MAR 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

149733

County of Nezperce

City of Lewiston

No. 508-6th Ave St.

Registration District No. 96

File No. _____

Hospital _____

Primary Registration District No. 1009

Registered No. Stillborn

FULL NAME OF CHILD premature Baby Burton

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Feb 24</u> 192 <u>7</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER		MOTHER	
FULL NAME <u>Thos. A. Burton</u>	FULL MAIDEN NAME <u>Georgia Bender</u>	FULL NAME <u>Thos. A. Burton</u>	FULL MAIDEN NAME <u>Georgia Bender</u>
RESIDENCE <u>1903-East Glass Avenue</u>	RESIDENCE <u>Spokane, Washington</u>	RESIDENCE <u>1903-East Glass Avenue</u>	RESIDENCE <u>Spokane, Washington</u>
COLOR <u>white</u>	COLOR <u>white</u>	COLOR <u>white</u>	COLOR <u>white</u>
AGE AT LAST BIRTHDAY <u>27</u> (Years)	AGE AT LAST BIRTHDAY <u>18</u> (Years)	AGE AT LAST BIRTHDAY <u>27</u> (Years)	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Washington</u>	BIRTHPLACE <u>Washington</u>	BIRTHPLACE <u>Washington</u>	BIRTHPLACE <u>Washington</u>
OCCUPATION <u>mechanic</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>mechanic</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 A. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Paul W. Johnson

(Physician or midwife)

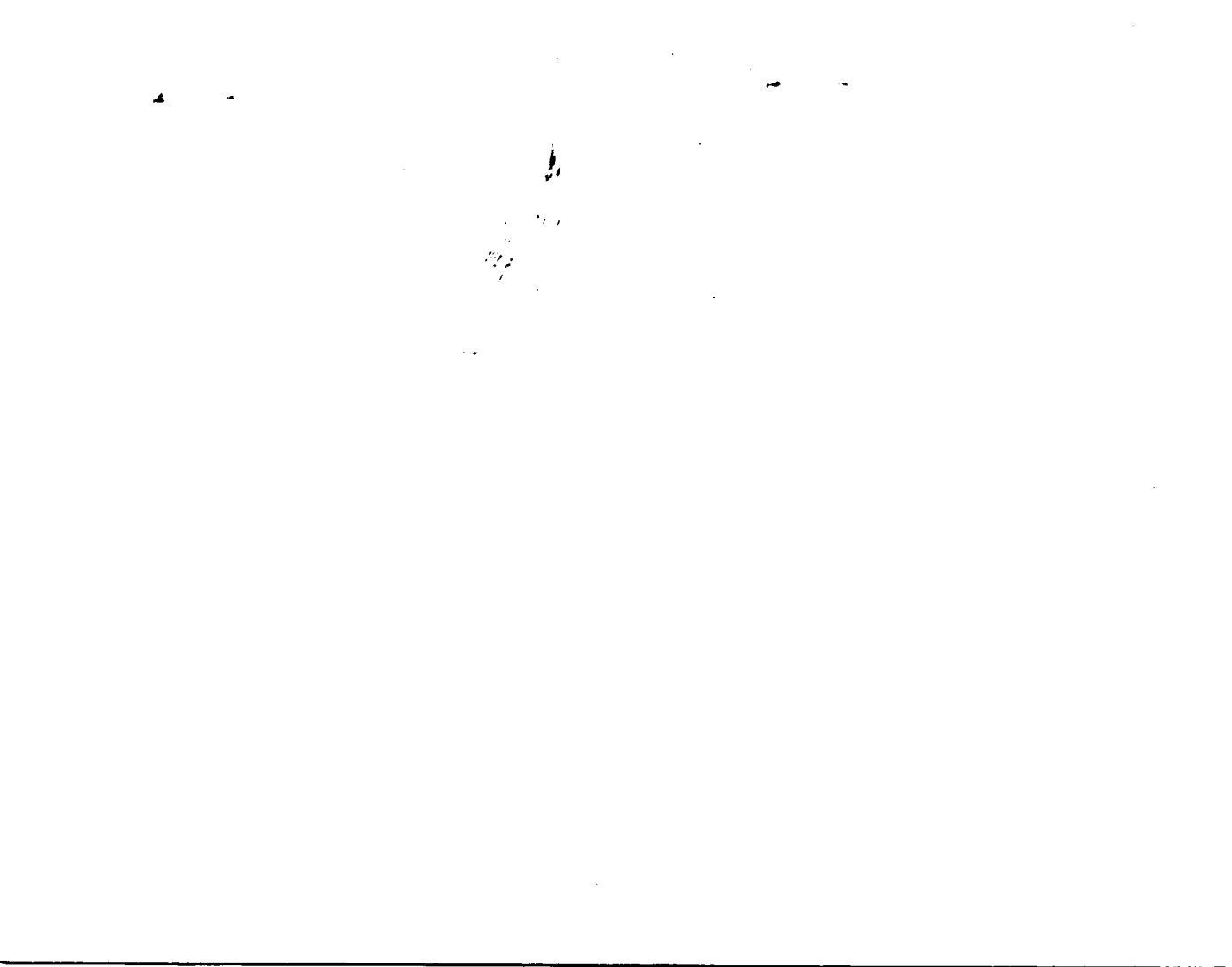
Give names added from a supplemental report.

Address Lewiston, Idaho

Filed Mar 9 1927 Susan E Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **56676**

PLACE OF DEATH

County of Blaine
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Burton

(a) Residence. No. 508—6th Ave St

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 2/24/27

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Thos. O. Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Burton
(Address) Lewiston, Idaho.

15 Filled Mar 9, 1927 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 24 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to Feb 24, 1927, that I last saw him alive on Still born, 1927, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

not known. - Give
months for fetus, had been dead
several days.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____
Was there an autopsy? no

What test confirmed diagnosis? none
(Signed) Paul W. Johnson, M. D.
2/24 1927 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 2/24 1927

20. Undertaker Brooks-Wann Co. Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Adynamia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

659-217-040-459
PLACE OF BIRTH

RECEIVED MAR 14

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of _____

City of Wallace

CERTIFICATE OF BIRTH 149777

No. _____ St. Registration District No. 70 State File No. _____

Hospital _____ Primary Registration District No. 1011 Local Registrar's No. 13

FULL NAME OF CHILD Hilda May Wingart

(Certificate of no value without full name of child)

Sex of Child <u>♀</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>July 17</u> 192 <u>7</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? No Ye. Arg. uprol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Matthias Hubert Wingart
RESIDENCE Wallace
COLOR H AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Montana
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Helena Merrill
RESIDENCE Wallace
COLOR H AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Montana
OCCUPATION Hom

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 2 10 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) James R. Ben

(Physician or midwife)

Address _____

Filed Jan 8 1927 Chas. E. Lindsey

Registrar.

Registrar.



SECRET

DEPARTMENT OF DEFENSE

BUREAU OF THE ARMY

WASHINGTON

1951

DEC 4 1951

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

263-101-040-366
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

1978

110780

County of Shoshone

City of Wallace

No. St. Registration District No. 70 State File No.

Hospital Wallace Primary Registration District No. 10.11 Local Registrar's No. 9

FULL NAME OF CHILD

Stillborn
(Certificate of no value without full name of child)

Sex of Child

M.

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Feb 1 -
(Month) (Day)

1927
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Samuel Boeking

RESIDENCE

Wallace Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

28
(Years)

BIRTHPLACE

Ireland

OCCUPATION

Book Keeper

FULL
MAIDEN
NAME

MOTHER

Blanche Towsley

RESIDENCE

Wallace

COLOR

White

AGE AT LAST

BIRTHDAY

28
(Years)

BIRTHPLACE

Canada

OCCUPATION

H. wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1045 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. Werlich

(Physician or midwife)

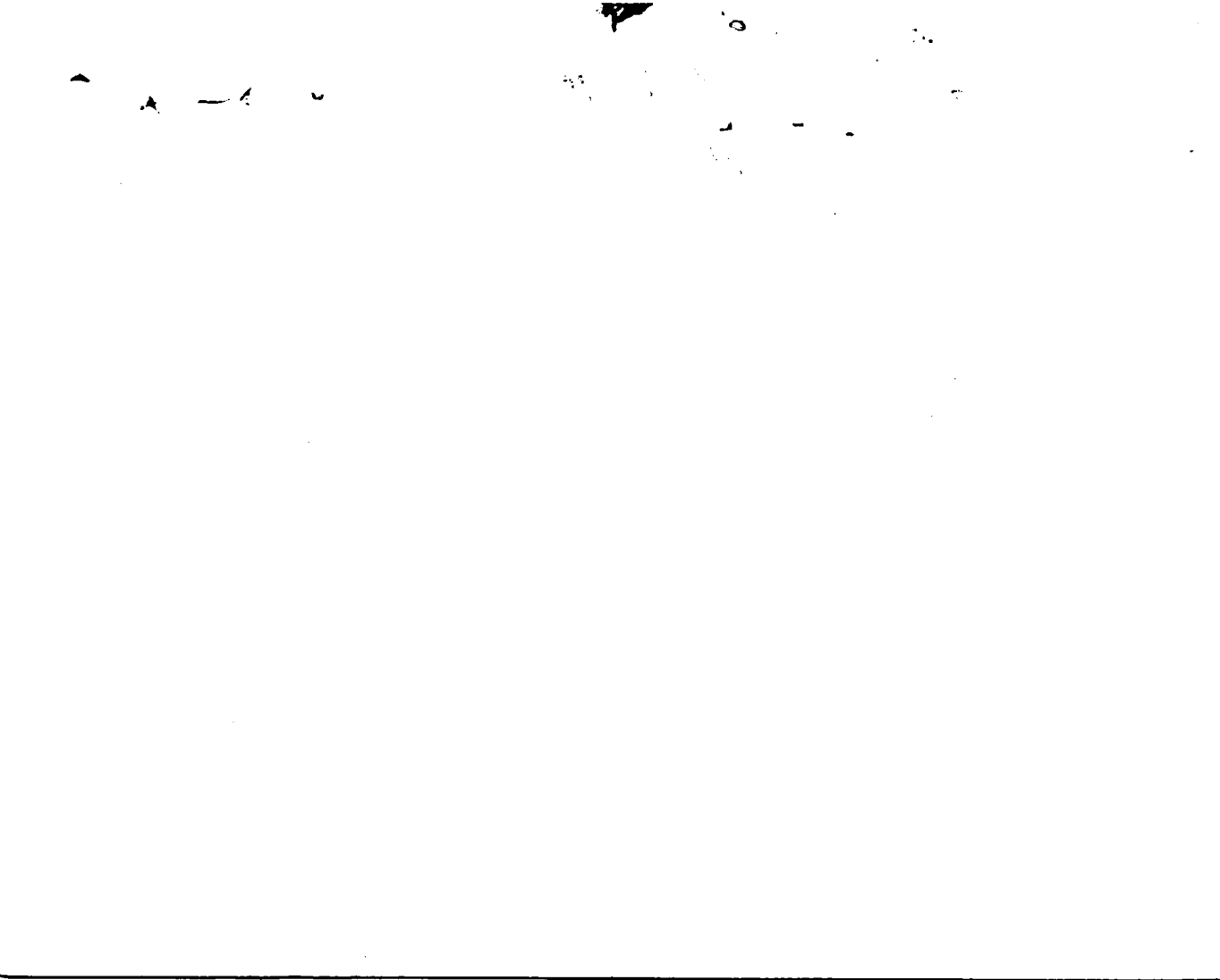
Address

Filed

1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		DO NOT WRITE IN THIS SPACE State File No. <u>56705</u>	
<p>RECEIVED <u>WAR 14</u></p> <p>PLACE OF DEATH <u>Shoshone</u></p> <p>County of <u>Shoshone</u> Registration District No. <u>7</u></p> <p>City of <u>Wallace</u> Primary Registration District No. <u>1011</u></p> <p>(No. <u>Wallace, Idaho</u>)</p> <p>(If death occurred in a hospital or institution, give its name instead of street and number.)</p>		<p>Local Registrar's No. <u>14</u></p>	
<p>2. FULL NAME <u>Infant of Mrs. S. Bock King</u></p> <p>(a) Residence. No. <u>8 Cottage Road</u> St. <u>4</u></p> <p>(Usual place of abode)</p> <p>Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.</p>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word)	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of			
6 DATE OF BIRTH (month, day and year) <u>July 1st 1927</u>			
7 AGE Years —	Months —	Days <u>0</u>	If LESS than day, hrs. or min.
8 OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work			
(b) General nature of industry, business, or establishment in which employed (or employer)			
(c) Name of employer			
9 BIRTHPLACE (city or town) <u>Wallace Ida</u> (State or country)			
PARENTS	10 NAME OF FATHER <u>S. Bock King</u>		
	11 BIRTHPLACE OF FATHER (city or town) <u>Dublin, Ireland</u> (State or country)		
	12 MAIDEN NAME OF MOTHER <u>Blanche Towles</u>		
	13 BIRTHPLACE OF MOTHER (city or town) <u>Greenville Ont</u> (State or country)		
14 Informant <u>S. Bock King</u> (Address) <u>Wallace Idaho</u>			
15 Filed <u>Feb 2, 1927</u> <u>W. L. Lingley</u> Registrar			
MEDICAL CERTIFICATE OF DEATH <u>1896</u>			
16 DATE OF DEATH <u>Feb</u> (Month) <u>1</u> (Day) <u>1927</u> (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 1, 1927</u> , to <u>Feb 1, 1927</u> that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> <u>Marasmus</u> (duration) _____ yrs. <u>3</u> mos. _____ ds.			
CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.			
18 Where was disease contracted If not at place of death?			
Did an operation precede death? <u>N/A</u> Date of _____			
Was there an autopsy? <u>N/A</u>			
What test confirmed diagnosis? <u>Physician's Examination</u> (Signed) <u>W. L. Lingley, M. D.</u> <u>2-1</u> , 19 <u>27</u> (Address) <u>Wallace, Ida</u>			
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
19 Place of Burial, Cremation, or Removal <u>Wallace Idaho</u>		Date of Burial <u>2-2</u> 19 <u>27</u>	
20 Undertaker <u>Prince Mortel</u>		Address <u>Wallace</u>	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

692-122-001-692
PLACE OF BIRTH
RECEIVED APR 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

149896

County of Ada

City of Boise

No. Stillborn

Registration District No. 2

State File No.

Hospital Group

Primary Registration District No. 104

Local Registrar's No. 106

FULL NAME OF CHILD (Stillborn) Wiseman

(Certificate of no value without full name of child)

Sex of Child male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? (no)

Date of
birth

May 22 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Clark Lupton

RESIDENCE

Turn Falls Idaho

COLOR

white

AGE AT LAST
BIRTHDAY 30
(Years)

BIRTHPLACE

Idaho

OCCUPATION

farmer

FULL
MAIDEN
NAME

MOTHER

Ada Wiseman

RESIDENCE

Turn Falls Idaho

COLOR

white

AGE AT LAST
BIRTHDAY 36
(Years)

BIRTHPLACE

Washington

OCCUPATION

housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:15 a.m. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Ernie

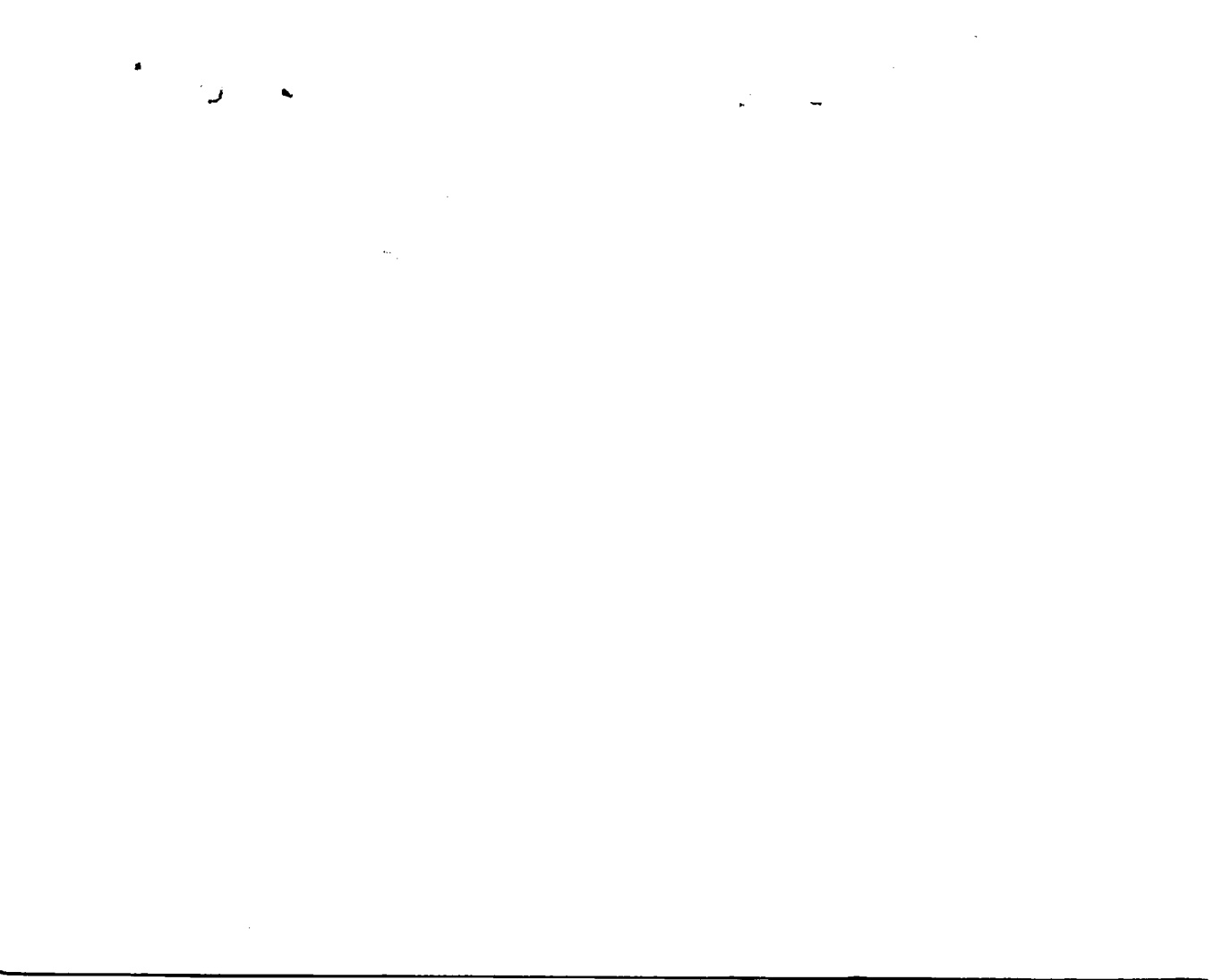
(Physician or midwife)

Address

Filed 3-29 1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

RECEIVED APR 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56762

County of Ada
City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 61

(No. Salvation Army Home)
If death occurred in a hospital or institution, give its name instead of street and number.

2. FULL NAME Baby Wiseman

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. da. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W. 5 Single Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 3/22/27

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10 NAME OF FATHER Clark Tyston

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ada Wiseman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm. Bratney
(Address) Boise, Idaho.

15 Filled 3-23 19 27 R. N. Brady
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 22, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: 6:30 am

still born baby (born dead for 2 weeks before birth)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Unknown
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted not known
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? none
(Signed) Dr. J. J. Sullivan, M. D.
_____ 1927 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Marion Hill Date of Burial 3-25 1927

20. Undertaker Marion Hill Address Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

814-114-003-715
PLACE OF BIRTH

RECEIVED

MAR 16 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

County of Bannock
City of Swan Lake

CERTIFICATE OF BIRTH 149941

No. _____ St. _____ Registration District No. 83 State File No. _____

Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 283

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Jan. 14, 1927</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FULL NAME FATHER
Alma E. Hadley

FULL MAIDEN NAME MOTHER
Elizabeth Panting

RESIDENCE Swan Lake, Idaho

RESIDENCE Swan Lake, Idaho

COLOR White AGE AT LAST BIRTHDAY 46
(Years)

COLOR White AGE AT LAST BIRTHDAY 44
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Idaho

OCCUPATION Farming

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { born alive } at _____ P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. R. Cutler

Physician

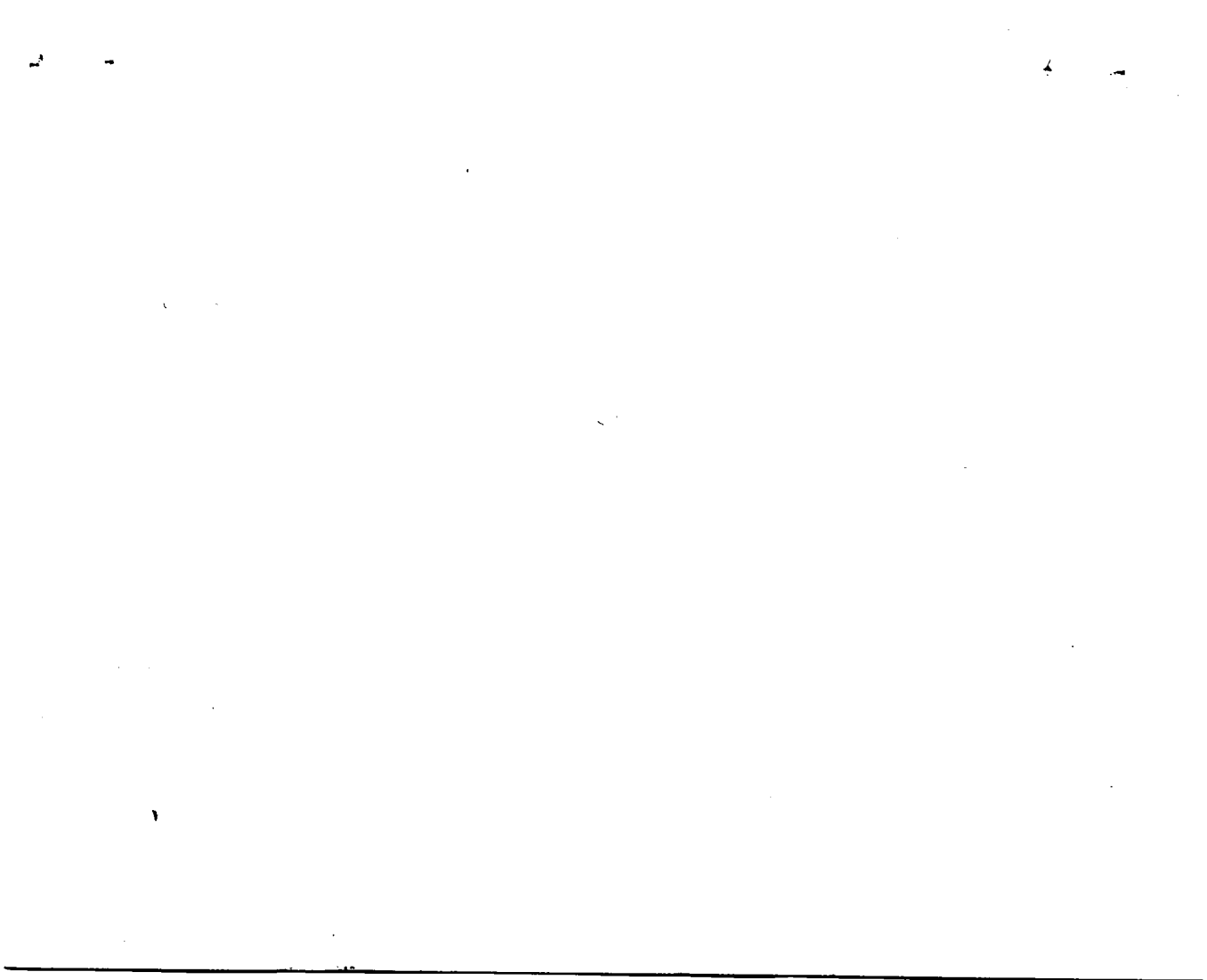
(Physician or midwife)

Address Preston, Idaho

Filed Mar 10, 1927 Mary C. Coffin

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-18

1. PLACE OF DEATH

County of BannockCity of Swan Lake

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 88Primary Registration District No. 2160

(No. _____ St.)

StillbornSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 56802

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White

Single

(Write the word)

6. DATE OF BIRTH

Jan. 14, 1927

(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day how many hrs. or min.?
0

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Swan Lake, Idaho

10. NAME OF

Father

Alma E. Hadley

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Elizabeth Panting

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alma E. Hadley

(Address)

Swan Lake, Idaho

15.

Filed Mar. -10-27 Mary C. Coffey

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 14, 1927

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1927 to Jan. 14, 1927that I last saw him alive on Jan. 14, 1927and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Encephalic Monster

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.
-15-1927 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Swan Lake, Idaho

DATE OF BURIAL

1-15-27 19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

799 Del 883 - 405
PLACE OF BIRTH

RECEIVED MAR 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

County of Bonner

City of Pocatelli

CERTIFICATE OF BIRTH 149951

No. _____ St. _____

Registration District No. 28

File No. _____

Hospital _____

Primary Registration District No. 2161

Registered No. 8059

FULL NAME OF CHILD

Doran Price

(Certificate of no value without full name of child.)

Sex of Child male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
(in order
of birth
9

Legiti-
mate? yes

Date of birth Feb 24 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 9

Number of children of this mother now living, including present birth. None

FULL NAME FATHER G. H. Price

FULL MAIDEN NAME MOTHER Ora Jones

RESIDENCE Pocatelli

RESIDENCE Idaho

COLOR white AGE AT LAST BIRTHDAY 40 (Years)

COLOR white AGE AT LAST BIRTHDAY 34 (Years)

BIRTHPLACE Texas

BIRTHPLACE OKla.

OCCUPATION Fireman

OCCUPATION Idaho

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M. on the date above stated. (Born ~~live~~ or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. S. Miller

(Physician or midwife)

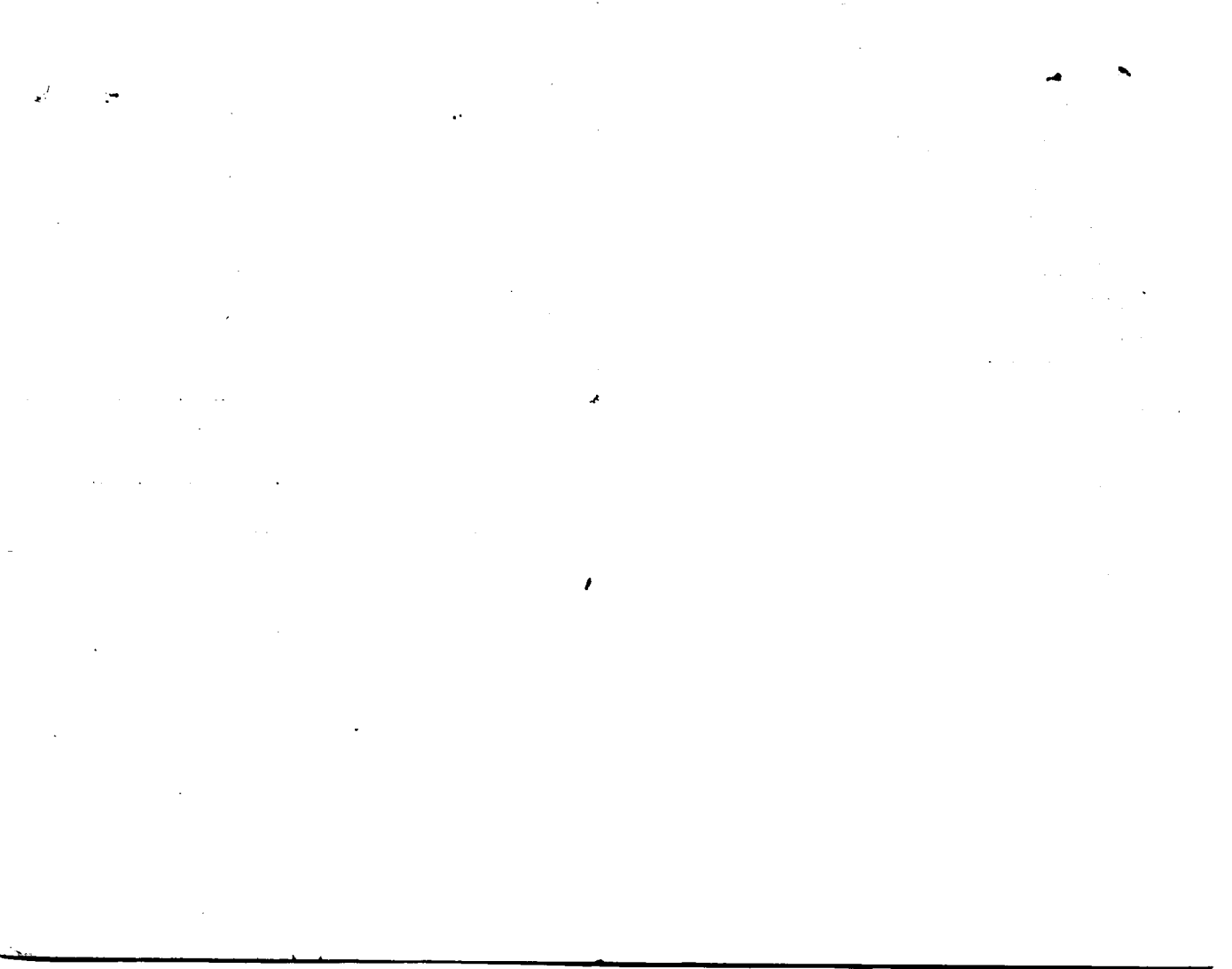
Give names added from a supplemental report.

Address Pocatelli

Filed 3/1 1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH RECEIVED MAR 1 1927

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
56788
State File No.

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141

Local Registrar's No. 4995

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Price

(a) Residence. No. 633 N Grant St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 24 - 1927

7 AGE

Years

Months

Days

1 If LESS than
day, hrs.
or min.

Still

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pocatello, Idaho
(State or country)

10 NAME OF FATHER

C. H. Price

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Pager, Texas

12 MAIDEN NAME OF MOTHER

Ma Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Oklahoma City, Okla.

14

Informant

F. S. Miller

(Address)

Pocatello, Idaho

15

Filed

2/25 1927

Registrar

J. H. Jones

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 24

(Month)

(Day)

1927
(Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to _____, 19____.

that I last saw him alive on Feb 24, 1927.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

F. S. Miller

M. D.

Feb. 25, 1927

(Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Blackfoot Idaho

2-25-1927

20. Undertaker

Address

E. J. Teek

Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

469-125-003-555
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello
No. 28 St. Registration District No. 28 State File No. 149984
Hospital Pocatello Primary Registration District No. 2161 Local Registrar's No. 8061
FULL NAME OF CHILD Stillbirth

RECEIVED MAR 17 1927 CERTIFICATE OF BIRTH

149984

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>2-25</u> 192 <u>7</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Bert Thomas Morris
RESIDENCE Pocatello Idaho
COLOR wht AGE AT LAST BIRTHDAY 53 (Years)
BIRTHPLACE Utah
OCCUPATION Sheepman

MOTHER
FULL MAIDEN NAME Helen Keeley
RESIDENCE Same
COLOR wht AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE Utah
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at on the date above stated. 7:30 A. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D. C. Ray

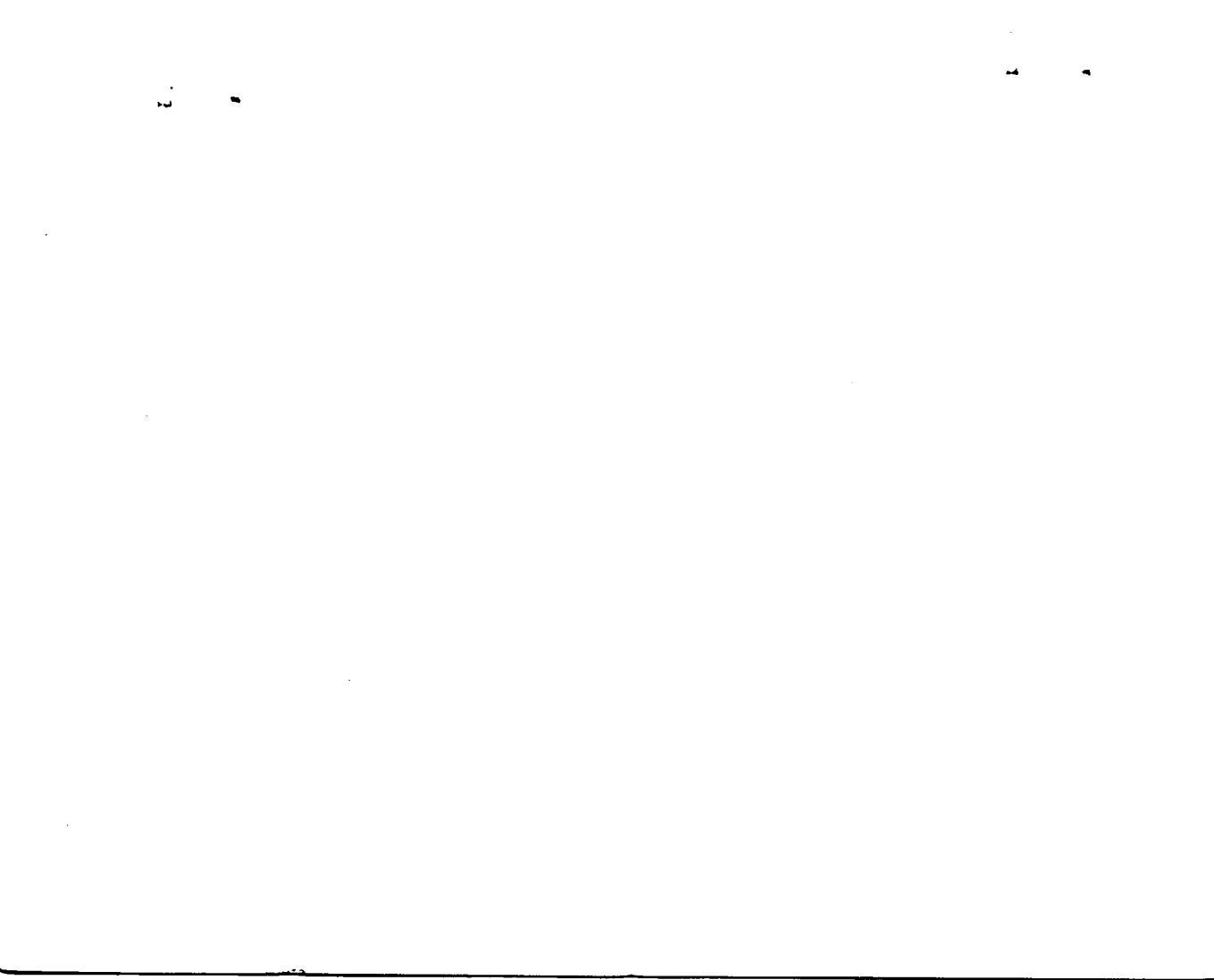
(Physician or midwife)

Address Pocatello Idaho

Filed 3/1 1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 17 1927 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

56786

State File No.

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2741
(No. General Hospital)

Local Registrar's No. 4997

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ray Morris

(a) Residence. No. Pocatello Ida. St.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

16 DATE OF DEATH February 25 19 27
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 19 27, to 2-25, 19 27, that I last saw him alive on 2-25, 19 27, and that death occurred, on the date stated above, at 2 m.

6 DATE OF BIRTH (month, day and year) February 25-1922
7 AGE Years 4 Months 0 Days 0 If LESS than 1 day, 0 hrs. or 0 min.

The CAUSE OF DEATH* was as follows:
Still birth. died in
utero-- Lucie
(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

18 Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?

10 NAME OF FATHER B. Thomas Morris

What test confirmed diagnosis?
(Signed) D. C. Ray M. D.
2-26, 19 27 (Address) Pocatello

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Helen Husley

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant B. Thomas Morris
(Address) Pocatello

19 Place of Burial, Cremation, or Removal Mountain View Bur Date of Burial Feb 26 19 27

15 Filed 4-26, 19 27 J. H. Hanning Registrar

20. Undertaker Schumacher & Hall Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDIAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

238-204-206-552
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bingham **RECEIVED MAR 11 1927**

City of Aberdeen

CERTIFICATE OF BIRTH **S**
150062

No. St. Registration District No. 116 State File No.

Hospital Primary Registration District No. 2195 Local Registrar's No. 1

FULL NAME OF CHILD Evangeline Schmidt
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 7</u> 192 <u>7</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME David J. Schmidt
RESIDENCE Aberdeen, Idaho
COLOR white AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Kansas
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Mary Moss
RESIDENCE Aberdeen
COLOR white AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Kansas
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192

(Signature) Dr. C. F. Schiltz
(Physician or midwife)

Address Am. Falls, Idaho

Filed Feb 12 192 7 M. C. Mark

Registrar.

Registrar.

DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON

#3

Division of
al Statistics.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

R. M. Fouch, M. D.,
Special Agent,
Boise, Idaho.

Mrs. David J. Schmidt
Aberdeep, Idaho

~~FEB 16 1927~~

APR 18 1927
RECEIVED MAY 13 1927

150062

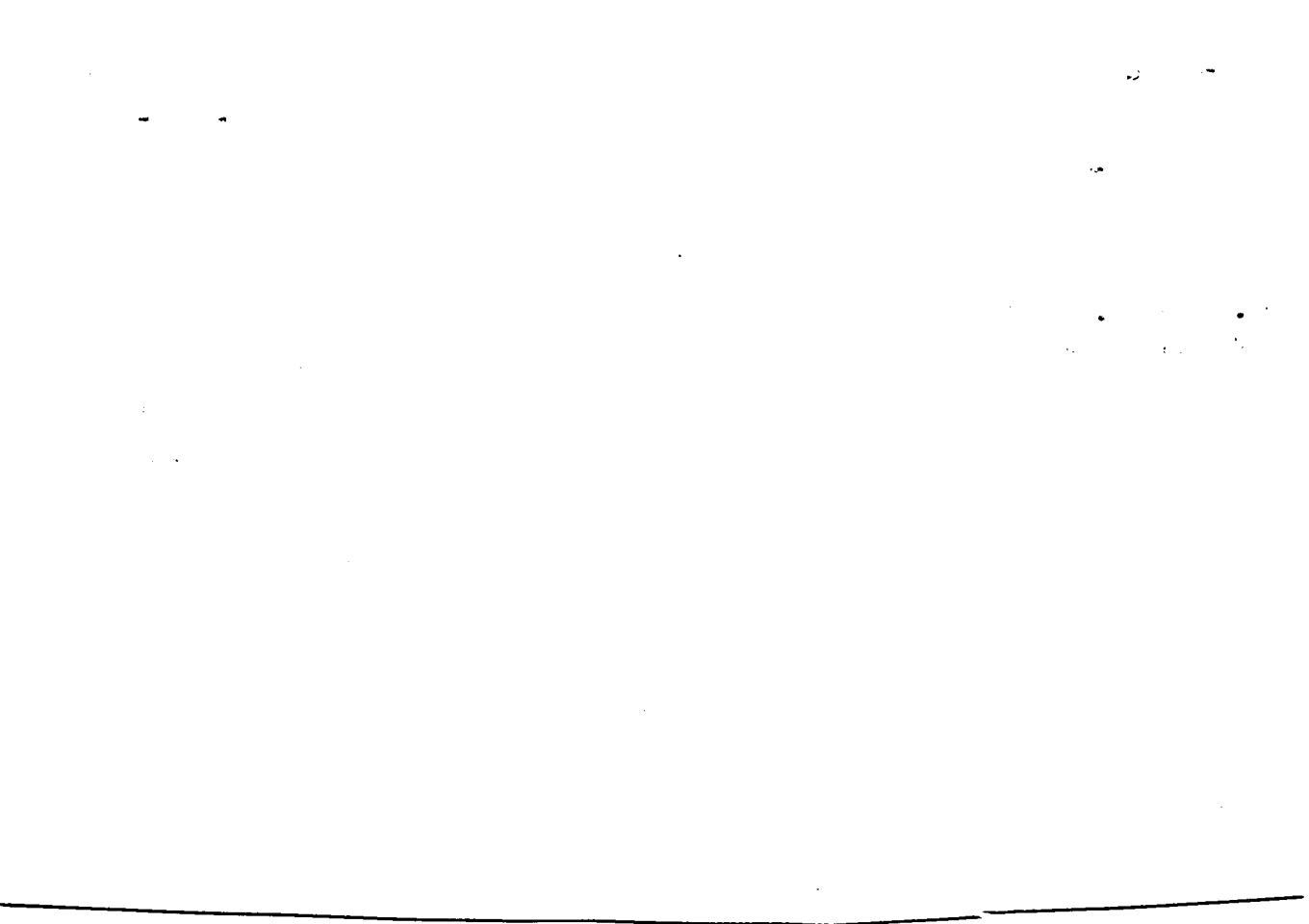
ar Madam:

Idaho is now in the United States birth registration area and it is essential that birth certificates be made complete in every particular in order that proper classification may be made. We therefore respectfully ask that you kindly give us the information opposite the items below which we have checked. These items are missing on the certificate of birth filed for your child. You need not fill in the items not checked.

As soon as we receive from you the information for which we have asked we will forward to you a certificate for your child.

ne ✓ Everglene Schmidt

on



1. PLACE OF RECEIVED MAR 11 1927 CERTIFICATE OF DEATH
 Registration District No. 116
 County of Bingham Primary Registration District No. 2193
 City of _____ (No. _____, _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 56831
 Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

July 4 1927
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?
 Yrs. Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David J. Schmidt

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mary Cress

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David J. Schmidt

(Address)

Union Falls, Ida.

15.

Filed Feb 12 1927

27

McMurry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

189-6

16. DATE OF DEATH

July 4 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____,
 that I last saw h_____ alive on 19____,
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. C. F. Phelps M. D.

9/5 1927 (Address) Union Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Memorial Cemetery

DATE OF BURIAL

2/6 1927

20. UNDERTAKER

Harvey

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

795-122-010-713
PLACE OF BIRTH

RECEIVED APR 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bannock

City of Idaho Falls

No. Memorial Registration District No. 73 State File No. 150082

Hospital St. L. Primary Registration District No. 2ND Local Registrar's No. 113

FULL NAME OF CHILD Stillbirth

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>0</u>	and { Number in order of birth <u>0</u> }	Legitimate? <u>Yes</u>	Date of birth <u>3-22-1927</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth None

FATHER
FULL NAME Harvey Greenwood
RESIDENCE Shelley, Idaho
COLOR White AGE AT LAST BIRTHDAY 43
(Years)
BIRTHPLACE Utah
OCCUPATION Chemist

MOTHER
FULL MAIDEN NAME Viola C. Patterson
RESIDENCE Shelley, Idaho
COLOR White AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Boys } at 3¹⁴ 9 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) [Signature]

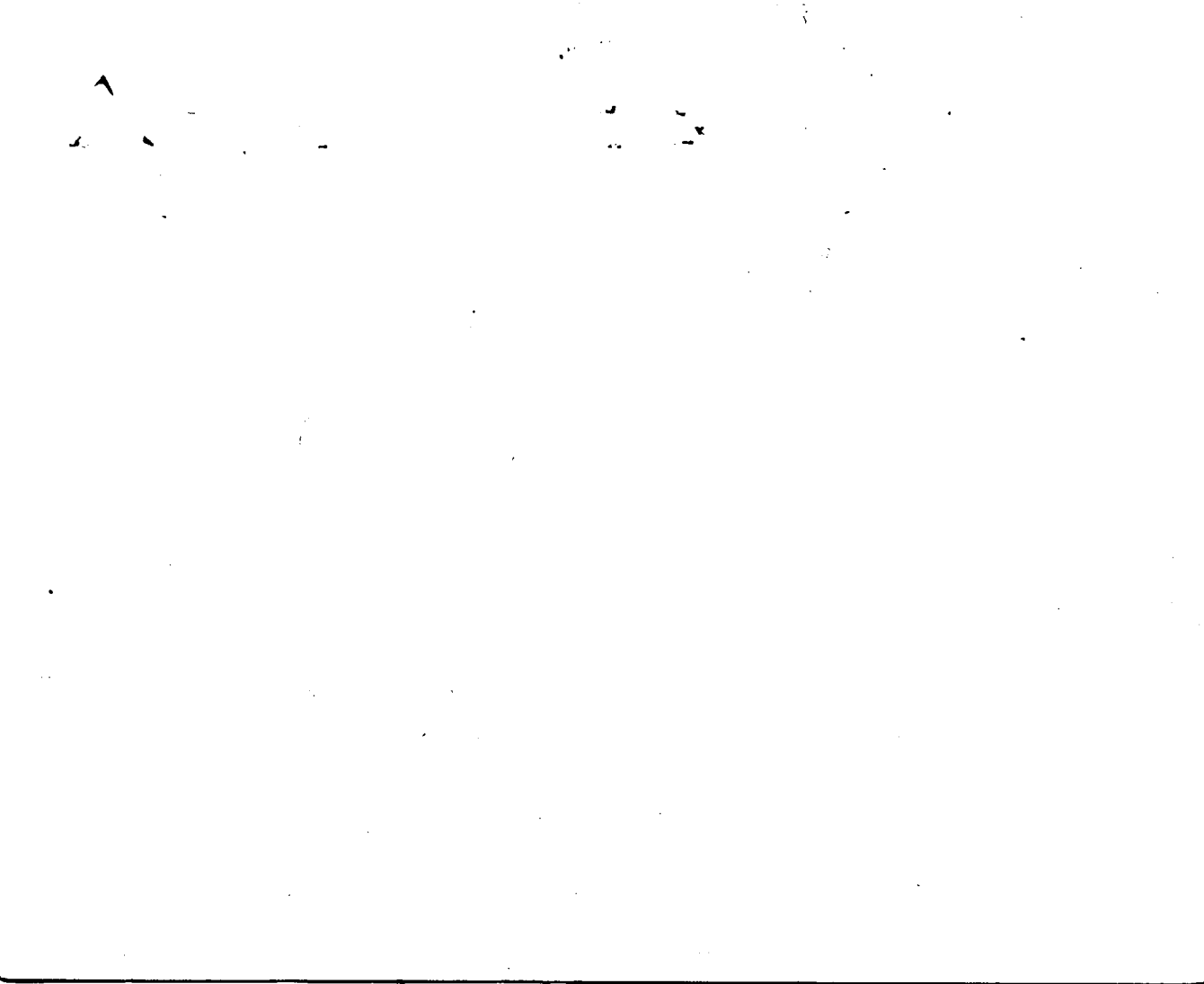
(Physician or midwife)

Address Idaho Falls, Ida.

Filed Mar 23 1927 [Signature]

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. RECEIVED APR 9 1927		CERTIFICATE OF DEATH		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS	
1. PLACE OF DEATH County of <u>Bonneville</u> City of <u>Idaho Falls</u>		Registration District No. <u>73</u> Primary Registration District No. <u>2128</u> (No. _____ St.)		State File No. <u>56844</u> Local Registrar's No. <u>29</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Stillbirth</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH <u>189</u>	
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u> (Write the word)		16. DATE OF DEATH <u>3</u> (Month) <u>22</u> (Day) <u>1927</u> (Year)	
5. SINGLE, MARRIED, WIDOWED OR DIVORCED		6. DATE OF BIRTH <u>3</u> (Month) <u>22</u> (Day) <u>1927</u> (Year)		17. I HEREBY CERTIFY, That I attended deceased from <u>19</u> to <u>19</u> , that I last saw him alive on <u>19</u> , and that death occurred on the date stated above, at <u>M.</u> The CAUSE OF DEATH* was as follows: <u>Stillborn</u> <u>Hydramnios</u> (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. Contributory (Secondary) _____ (Duration) <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. (Signed) <u>Cell Cleve M. D.</u> <u>19</u> (Address) <u>Idaho Falls, Id.</u>	
7. AGE <u>Stillbirth</u> Yrs. _____ Mos. _____ ds. _____ IF LESS than 1 day how many hrs. or min.?		8. OCCUPATION _____			
9. BIRTHPLACE (State or Country) <u>Bonneville</u>		10. NAME OF FATHER <u>Harvey Greenwood</u>			
11. BIRTHPLACE OF FATHER (State or Country) <u>Utah</u>		12. MAIDEN NAME OF MOTHER <u>Vivian C. Patterson</u>			
13. BIRTHPLACE OF MOTHER (State or Country) <u>Utah</u>		14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harvey Greenwood</u> (Address) <u>Idaho Falls, Idaho</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____ Former or usual residence _____	
15. <u>Apr 22</u> 19 <u>27</u> <u>Gray</u> Local Registrar		19. PLACE OF BURIAL OR REMOVAL <u>Idaho Falls, Id.</u>		DATE OF BURIAL <u>Apr 22</u> 19 <u>27</u>	
		20. UNDERTAKER <u>Cove</u>		ADDRESS _____	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

313-101-010-313
PLACE OF BIRTH RECEIVED APR 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of **Bonneville**
City of **Idaho Falls, Idaho.**

CERTIFICATE OF BIRTH 150099

No. _____ St. _____ Registration District No. **73** State File No. _____
Hospital **L. D. S.** Primary Registration District No. **2148** Local Registrar's No. **9V-**

FULL NAME OF CHILD **Later**
(Certificate of no value without full name of child)

Sex of Child Male	Twin Triplet or other? --	and { Number in order of birth --	Legitimate? Yes	Date of birth March, 1 1927 (Month) (Day) (Year)
--------------------------	----------------------------------	--	------------------------	--

What bactericidal solution was used in eyes? **None**

Number of child of this mother, including present birth 7	Number of child of this mother now living, including present birth 5
--	---

FULL NAME FATHER Lewis Later	FULL MAIDEN NAME MOTHER Chloe Camille Call
RESIDENCE Rigby, Idaho.	RESIDENCE Rigby, Idaho.
COLOR white AGE AT LAST BIRTHDAY 38 (Years)	COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Harrisville, Utah	BIRTHPLACE Rigby, Idaho.
OCCUPATION Mgr. of Lumber Co.	OCCUPATION Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { **born alive** } at **9:55** P. M.
on the date above stated. { **Stillborn** }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) _____
(Physician or midwife)

Address **Idaho Falls, Idaho.**
Filed **h-5** 1927 _____
Registrar. _____ Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

766-217-008-295
PLACE OF BIRTH

RECEIVED APR 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 150129

County of Bonneville
City of Prairie River

No. 82 State Registration District No. 82 State File No. 12

Hospital Primary Registration District No. 21.85 Local Registrar's No. 16

FULL NAME OF CHILD Pathe Esther Goodman

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>Mar. 17</u> 192 <u>7</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER		MOTHER	
FULL NAME <u>Perry Goodman</u>	FULL MAIDEN NAME <u>Gladys Breakfield</u>		
RESIDENCE <u>Prairie River</u>	RESIDENCE <u>Prairie River</u>		
COLOR <u>white</u>	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	
BIRTHPLACE <u>Nev.</u>	BIRTHPLACE <u>Okl.</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8:05 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

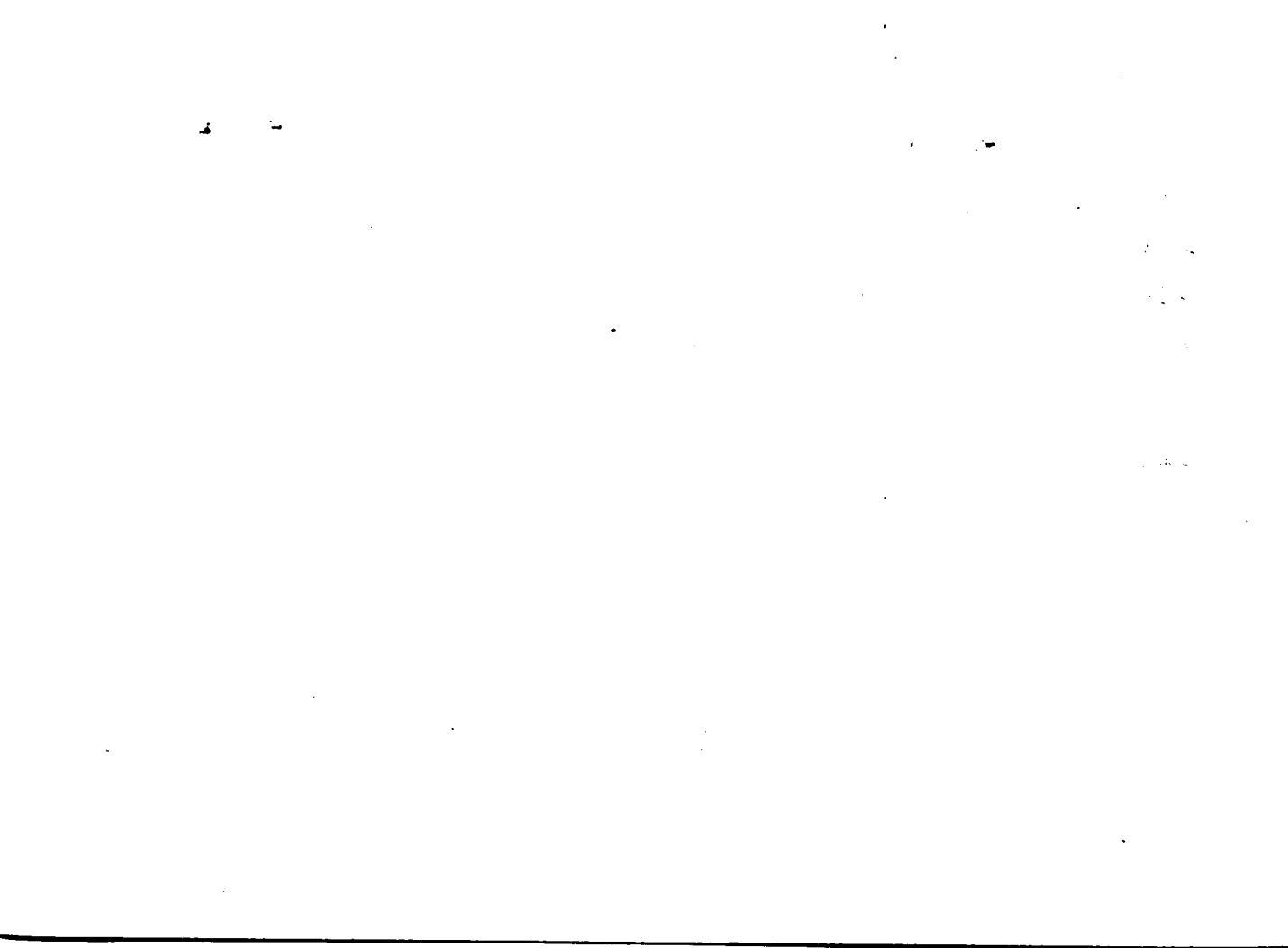
(Signature) E. E. Getzloff M.D.

(Physician or midwife)

Address Prairie River

Filed Apr 1 1927 E. E. Getzloff Registrar.

Registrar.



RECEIVED APR 9 1927

CERTIFICATE OF DEATH

56834

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonneCity of Priest RiverRegistration District No. 85Primary Registration District No. 21 85

(No. St.)

File No. 7Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Patricia Esther Goodman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

March 17 1927
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or 24 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. no

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Perry Goodman

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Gladys Breakfield

13. BIRTHPLACE OF MOTHER

(State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aunt Goodman(Address) Priest River, Idaho

15.

Filed Apr 10 19271927E. E. Getloff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 17 1927, to March 17 1927,
that I last saw him alive on March 17 1927 at 8:05 P.M.and that death occurred on the date stated above, at 8:05 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn (Prolonged difficult labor)

(Duration) Yrs. mos. ds.

Contributory Child too large
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Getloff M. D.March 17 1927 (Address) Priest River

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? —Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL

Priest River Idaho

DATE OF BURIAL

Mar 17 1927

20. UNDERTAKER

Perry Goodman

ADDRESS

Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

294-101014-888
PLACE OF BIRTH

RECEIVED APR 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Lampa

CERTIFICATE OF BIRTH

No. St. Registration District No. 7 State File No. 150139

Hospital Primary Registration District No. 1006 Local Registrar's No. 337

FULL NAME OF CHILD (unnamed) Kidd, (Stillborn)

(Certificate of no value without full name of child)

Sex of Child 2 Twin Twins and { Number in order of birth 1st Legitimate? Yes Date of birth 3-1-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME John T. Kidd
RESIDENCE 1716-2 St 20. Lampa
COLOR W AGE AT LAST BIRTHDAY 42
BIRTHPLACE Mo.
OCCUPATION Laborer
(Years)

MOTHER
FULL MAIDEN NAME Dorothy Alice Hook
RESIDENCE 1716-2 St 20 Lampa
COLOR W AGE AT LAST BIRTHDAY 29
BIRTHPLACE Medford Okla
OCCUPATION Housewife
(Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 3 A. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)

Address Lampa Idaho
Filed 3-31-1927 Max Terby Registrar.

Registrar.

THIS IS TO CERTIFY THAT THE CHILD NAMED ABOVE WAS BORN AT THE PLACE AND DATE HEREIN SET FORTH AND THAT THE SIGNATURE OF THE REGISTRAR IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD.

STATE OF NEW YORK
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
City of _____
County of _____
Hospital _____
Registration District No. _____
Local Registrar's No. _____
Full Name of Child _____
Gender of child without full name _____
Sex of Child _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Month _____
Day _____
Year _____

What supplemental notation was used in event _____
Number of child in this mother's family including present birth _____
FATHER'S NAME _____
MOTHER'S NAME _____
RESIDENCE _____
COLOR _____
BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____
COLOR _____
AGE AT LAST BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____
RESIDENCE _____
MOTHER'S NAME _____
FATHER'S NAME _____
RESIDENCE _____
COLOR _____
BIRTHDAY _____
BIRTHPLACE _____
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was _____
born at _____
on the date above stated.
When there was no attending physician or midwife then the father, mother or another person who was present at the birth should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Other names added from a supplemental report _____
Signature _____
Date _____
Address _____
City _____
State _____
Post Office _____
Registrar _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Blaine

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. 1716-238 St. No. St.)

State File No. 56581

Local Registrar's No. 277

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Buley Kidd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White

Single
(Write the word)

6. DATE OF BIRTH

March 1st 1927
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many

Yrs. Mos. ds. non hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF
Father

John T. Kidd

11. BIRTHPLACE
OF FATHER

(State or Country) Missouri

12. MAIDEN NAME
OF MOTHER

Dorothy Thacker

13. BIRTHPLACE
OF MOTHER

(State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John T. Kidd

(Address) Nampa Idaho

15.

Filed Mar 2 19 27 Mae Gerby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 1 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1-1927 to 4-1-1927

that I last saw him alive on 3-1-1927
and that death occurred on the date stated above, at 3:20 M.

The CAUSE OF DEATH* was as follows:

Still born. Due to
premature birth.

(Duration) 4 yrs. 4 mos. 2 ds.

Contributory
(Secondary)

(Duration) 4 yrs. 4 mos. 4 ds.

(Signed) J. E. Horton M. D.

1-1-1927 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawn Nampa

3-2 1927

20. UNDERTAKER

ADDRESS

Mrs. Nina M. Talley

Nampa Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc., "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

294-10140-863
PLACE OF BIRTH

RECEIVED APR 6 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Campan
City of Laurens
No. _____ St. _____ Registration District No. 7 State File No. 150140
Hospital _____ Primary Registration District No. 1006 Local Registrar's No. 336
FULL NAME OF CHILD (unnamed) Kidd Steelborn
(Certificate of no value without full name of child)

Sex of Child M. Twin ✓ Triplet ✓ and { Number in order of birth 2nd } Legiti- mate ✓ Date of birth 3-1 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Lowe

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME John J. Kidd
RESIDENCE 1716-2 St So Laurens
COLOR W. AGE AT LAST BIRTHDAY 42
(Years)
BIRTHPLACE Mo
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Dorothy Glavin Hacker
RESIDENCE 1716-2 St So Laurens
COLOR W. AGE AT LAST BIRTHDAY 24
(Years)
BIRTHPLACE Medford Okla
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:10 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1927

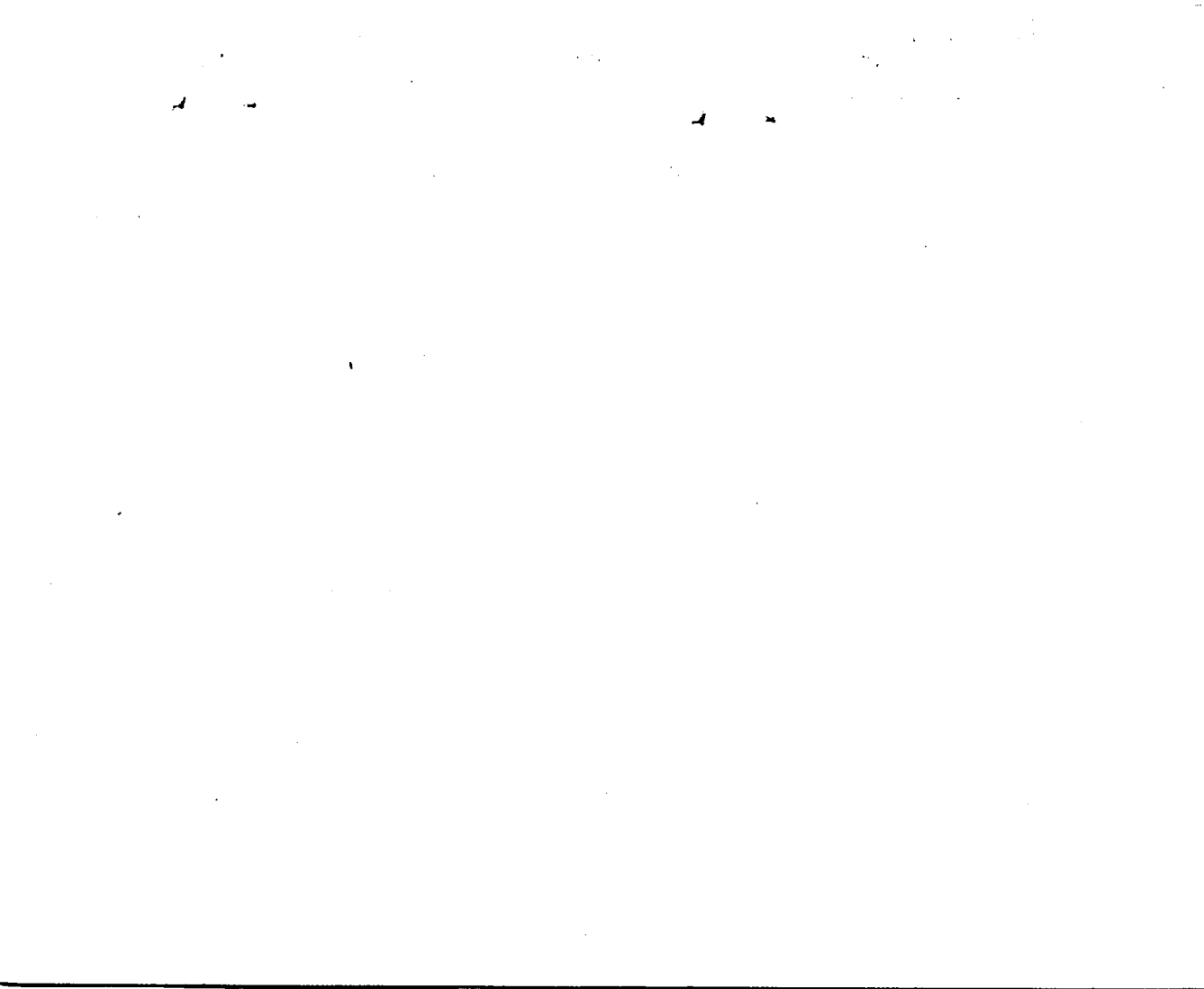
(Signature) J. C. Fortson
M. D.
(Physician or midwife)

Address Laurens, Idaho

Filed 3-31 1927 Mac Kerby
Registrar.

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH **RECEIVED MAR 7 1927**
County of Lanyon Registration District No. 7
City of Nampa Primary Registration District No. 106
(No. 1716-2nd St. No. St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Baby Kidd

State File No. 56586
Local Registrar's No. 276
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH March 1st 1927
(Month) (Day) (Year)

7. AGE None IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father John T. Kidd

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Dorothy Thacker

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. John T. Kidd
(Address) Nampa, Idaho

15. Filed Mar 2 1927 Mae Ferry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1st 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased ~~from~~ on 3-1-1927 to 19,
that I last saw him alive on 1-1-1927
and that death occurred on the date stated above, at 7:10 M.
The CAUSE OF DEATH* was as follows:
Sill low. Premature birth.

(Duration) 1 yrs. 5 mos. 1 ds.
Contributory (Secondary)
(Duration) 1 yrs. 1 mos. 1 ds.
(Signed) J. H. Hutton M. D.
7-1-1927 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Kohlerlawn, Nampa DATE OF BURIAL 3-2 1927
20. UNDERTAKER Mrs. Nina M. Talley ADDRESS Nampa Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

231-217-022-235
PLACE OF BIRTH

RECEIVED APR 8 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

150303

County of

City of

No. St. Registration District No. 99 State File No.

Hospital Primary Registration District No. 2177 Local Registrar's No. 641

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth <u>8</u>	Legitimate? <u>yes</u>	Date of birth <u>3</u> <u>17</u> <u>1927</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER	
FULL NAME	<u>Robert Blayer Jr.</u>
RESIDENCE	<u>Chester Idaho.</u>
COLOR	<u>White</u>
BIRTHPLACE	<u>Rexburg Idaho.</u>
OCCUPATION	<u>Farmer.</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)

MOTHER	
FULL MAIDEN NAME	<u>Mary Agnes Steel</u>
RESIDENCE	<u>Chester Idaho.</u>
COLOR	<u>White</u>
BIRTHPLACE	<u>Plano Idaho.</u>
OCCUPATION	<u>Wife</u>
AGE AT LAST BIRTHDAY	<u>27</u> (Years)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 10 10 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) P. M. Kelly, M. D.

(Physician or midwife)

Address St Anthony Idaho

Filed 4/6 1927 Wm Hansen

Registrar.

Registrar.

86120

PLACE OF BIRTH

RECEIVED APR 6 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

231 121-026-231

County of

City of

CERTIFICATE OF BIRTH

No. St. Registration District No. 98 State File No. 150432

Hospital Primary Registration District No. 2176 Local Registrar's No. 69

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <i>Male</i>	Twin Triplet or other? <i>\</i>	and {	Number in order of birth <i>\</i>	Legiti- mate? <i>No</i>	Date of birth <i>Jan 21</i>	1927
(To be answered only in event of plural births)					(Month)	(Day)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *3* Number of child of this mother now living, including present birth *0*

FULL NAME FATHER

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY (Years)

BIRTHPLACE

OCCUPATION

FULL MAIDEN NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY (Years) *20*

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { *Stillborn* } at *2:30 P. M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1927

Registrar.

(Signature)

(Physician or midwife)

Address

Filed

Ray H. Fisher M.A.
 Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 A. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

、大英帝国

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
56940
State File No.

PLACE OF DEATH

County of Jefferson
City of Rexburg

Registration District No. 78
Primary Registration District No. 2176

Local Registrar's No. 6

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. No name Stillborn St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rexburg - Ida.
(State or country)

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)

12. MAIDEN NAME OF MOTHER Gladys Statton

13. BIRTHPLACE OF MOTHER (city or town) Grace, Ida.
(State or Country)

14. Informant Gladys Statton
(Address) Grace, Idaho.

15. Filed Apr 10 1927 Ray H. Fisk Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____
that I last saw h_____ alive _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Baby was delivered 30 min. before my arrival. The people (Mrs. Ruben James Rexburg - 2241 P. St. I) was with woman and said baby was still born. I saw no marks of violence. (duration) _____ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of _____

Was there an autopsy? NO
What test confirmed diagnosis? Just have people's word for it

(Signed) John H. P. Wash. M. D.
John H. P. Wash. (Address) Rexburg, Ida.
by Ray H. Fisk m. d.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial Jan 22, 1927

20. Undertaker Friends Address Rexburg Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCounty of Now

RECEIVED MAR 21 1927

CERTIFICATE OF BIRTH

S
150455

City of

No. 238 718028 619St. Registration District No. 30

State File No.

Hospital

Primary Registration District No. 1051Local Registrar's No. 1201FULL NAME OF CHILD (un-named) Schreebeger

(Certificate of no value without full name of child)

Sex of Child

maleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthFeb 18 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

George M. SchreebegerFULL
MAIDEN
NAME

MOTHER

Goldie Farley

RESIDENCE

Post Falls - Ida R. I.

RESIDENCE

Post Falls - Ida R. I.

COLOR

whiteAGE AT LAST
BIRTHDAY23

(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY21

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

farmer

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7.15 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Frank H. Hargis
Physician

(Physician or midwife)

Give names added from a supplemental report.

March 17, 1927
D. D. Schreebeger

Address

Rathdrum, Idaho

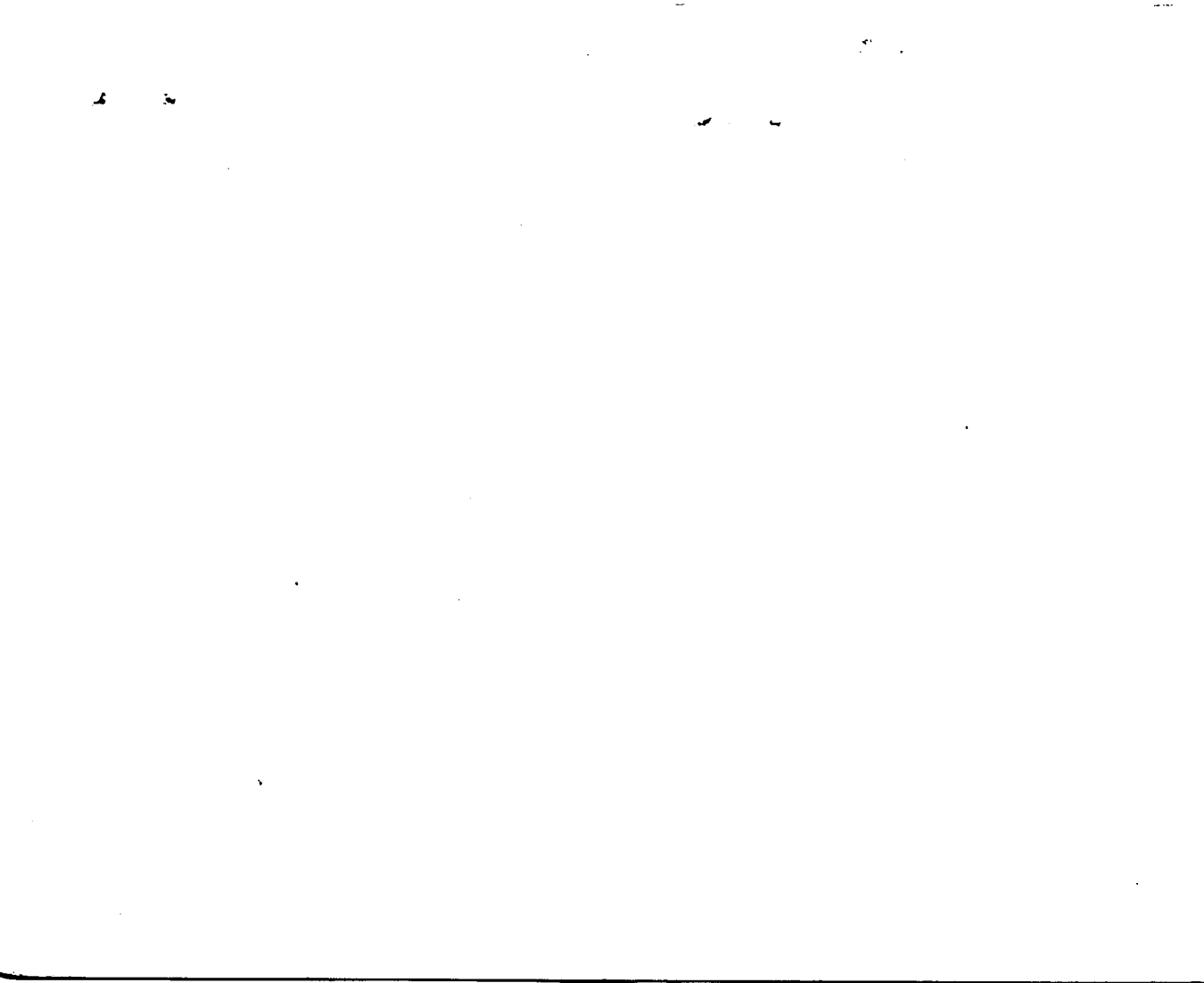
Filed

3/10 1927

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED MAR 21 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 56945

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Kootenai

Registration District No.

City of Pathtdum

Primary Registration District No.

Local Registrar's No. 1119

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (unnamed) Schueberger

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Feb 19, 1927

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

still born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Post Falls, Idaho

10 NAME OF FATHER

George J. Schueberger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kenilworth, N. J.

12 MAIDEN NAME OF MOTHER

Goldie S. Parley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Norfolk, Va.

14

Informant

(Address)

George J. SchuebergerPost Falls, Idaho

15

Filed

2/21, 1927D. D. Dunsen

Registrar

MEDICAL CERTIFICATE OF DEATH

1898

16 DATE OF DEATH

February 19, 1927

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927, to Feb 19, 1927that I last saw him alive on Feb 19, 1927and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn, premature birth, length of gestation less than 7 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Henry, M. D.2/20/27, 19... (Address) Post Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Post Falls Cemetery Feb 21, 1927

20. Undertaker

Address

Post Falls Cemetery Post Falls, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 21 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of *Boonville*

City of *Butter, Ida*

CERTIFICATE OF BIRTH

No. *463-217028413*

St.

Registration District No. *30*

State File No. *150470*

Hospital

Primary Registration District No. *1057*

Local Registrar's No. *1286*

FULL NAME OF CHILD *Helen Doshias*

(Certificate of no value without full name of child)

Sex of Child *F.*

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legitimate? *yes*

Date of birth *Feb 17 1927*

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *5*

Number of child of this mother now living, including present birth *4*

FULL NAME

FATHER

Christ Doshias

RESIDENCE

Butter

COLOR *W.*

AGE AT LAST BIRTHDAY *40*
(Years)

BIRTHPLACE *Greece*

OCCUPATION *Farmer & Dairymen*

FULL MAIDEN NAME

MOTHER

Ellen Doshias

RESIDENCE

Butter

COLOR *W.*

AGE AT LAST BIRTHDAY *39*
(Years)

BIRTHPLACE *Greece*

OCCUPATION *Wid.*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *(Stillborn)* at *6 P.* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Feb. 28, 1927

D. S. Doshias
Reg. M.S. Registrar.

(Signature)

D. S. Doshias
Physician
(Physician or midwife)

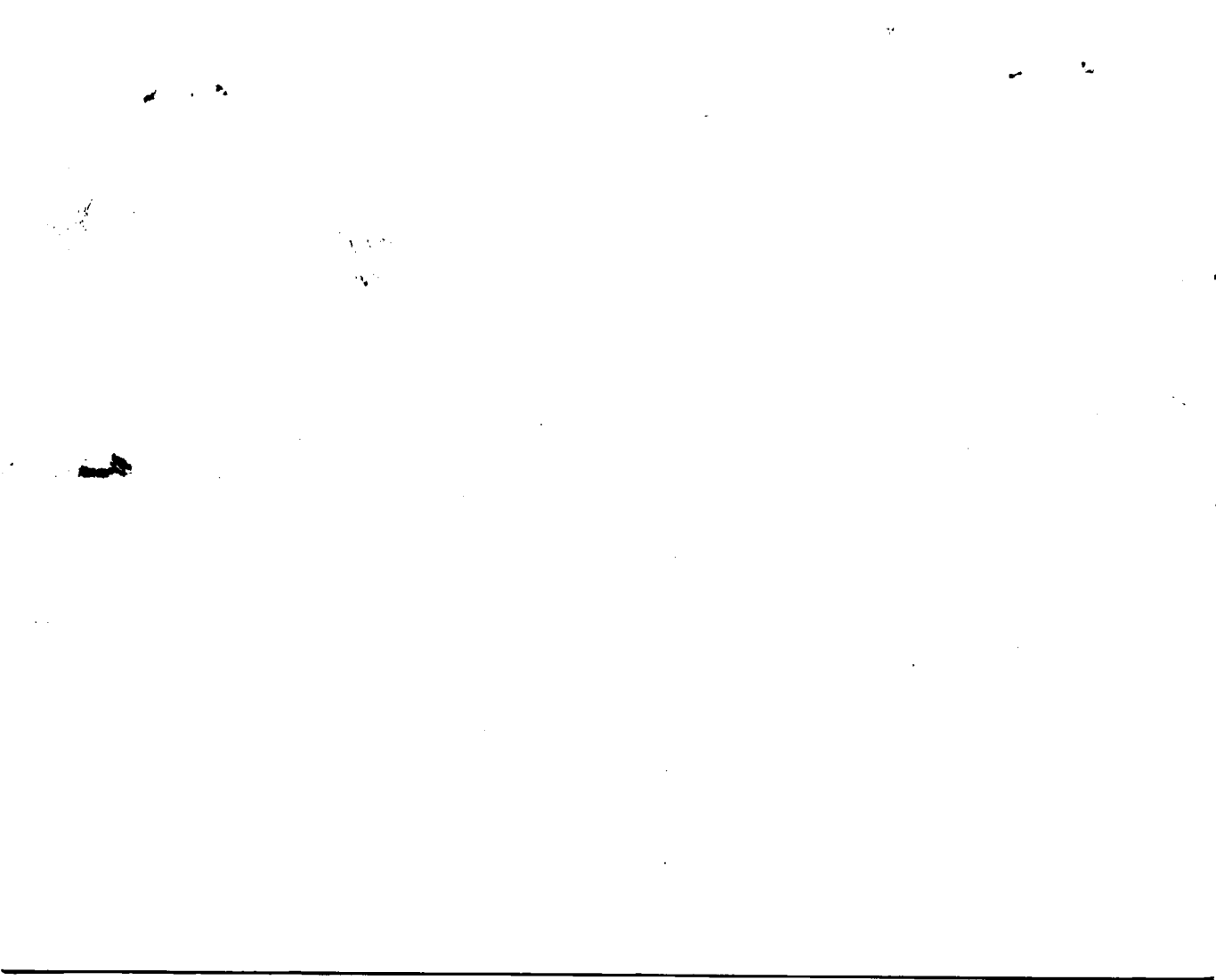
Address

Coeur d'Alene, Ida

Filed

Feb 17 1927

D. S. Doshias
Reg. M.S.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 21 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

56949

State File No.

Local Registrar's No. 1115

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Boole Registration District No.

City of Coeur d'Alene Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Dochios

(a) Residence. No. Hunter St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) single

16 DATE OF DEATH Feb. 17 19 27
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 19 27, to Feb 17, 19 27,
that I last saw her alive on Feb 17, 19 27,
and that death occurred, on the date stated above, at 6 P. m.

6 DATE OF BIRTH (month, day and year) 2-17-27

The CAUSE OF DEATH* was as follows:

7 AGE Years Months Days If LESS than 1 day, or 0 min. 0 0 0 0 hrs.

Stillborn
(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) 2 Kutter, Ida
(State or country)

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER Christ-Dochios

Did an operation precede death? no Date of

Was there an autopsy? no

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

What test confirmed diagnosis?

(Signed) D. D. Brennan M. D.

12 MAIDEN NAME OF MOTHER Helen Dalongjanios

Feb 17, 19 27 (Address) Coeur d'Alene

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant Christ Dochios
(Address)

19 Place of Burial, Cremation, or Removal Date of Burial

Forest Feb 19 19 27
20. Undertaker Address C. Cassidy C. Dalene

15 Filed 2/19, 19 27, D. D. Brennan
Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of IdahoCity of DearyNo. H 117029-793 St.

Hospital _____

FULL NAME OF CHILD _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

150485

Registration District No. 67 State File No. 9Primary Registration District No. 3147 Local Registrar's No. 40

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Feb. 17</u> 192 <u>7</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME <u>Gust Dahl</u>
RESIDENCE <u>Deary</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>53</u> (Years)
BIRTHPLACE <u>Sweden</u>
OCCUPATION <u>Manager</u>

MOTHER
FULL MAIDEN NAME <u>Katherine Pickard</u>
RESIDENCE <u>Deary</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)Address DearyFiled Feb. 17 1927

Registrar.

Registrar.

MAR 8 - 1954

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Deary

Registration District No. 67 56960
Primary Registration District No. 2147
(No. _____ St.)

State File No. 3
Local Registrar's No. 40

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Donald LaVenus Dahl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Mch. 17 1 1927
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Deary

10. NAME OF FATHER Gust Dahl

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Kathryn Pickens

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed Mch. 17 1927 C. K. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch. 17 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____, that I last saw him alive _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Asphyxiation - Stillborn - Poor Presentation
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. K. Smith M. D.
Mch. 17 1927 (Address) Deary - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Calona DATE OF BURIAL Mch. 17 1927

20. UNDERTAKER J. J. Pickens ADDRESS Deary - Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

466 214 030-291

County of

City of

No.

St.

Registration District No.

State File No.

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Sex of
Child

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Stillborn or at

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 150508

S

RECEIVED APR 12 1927

9 am.

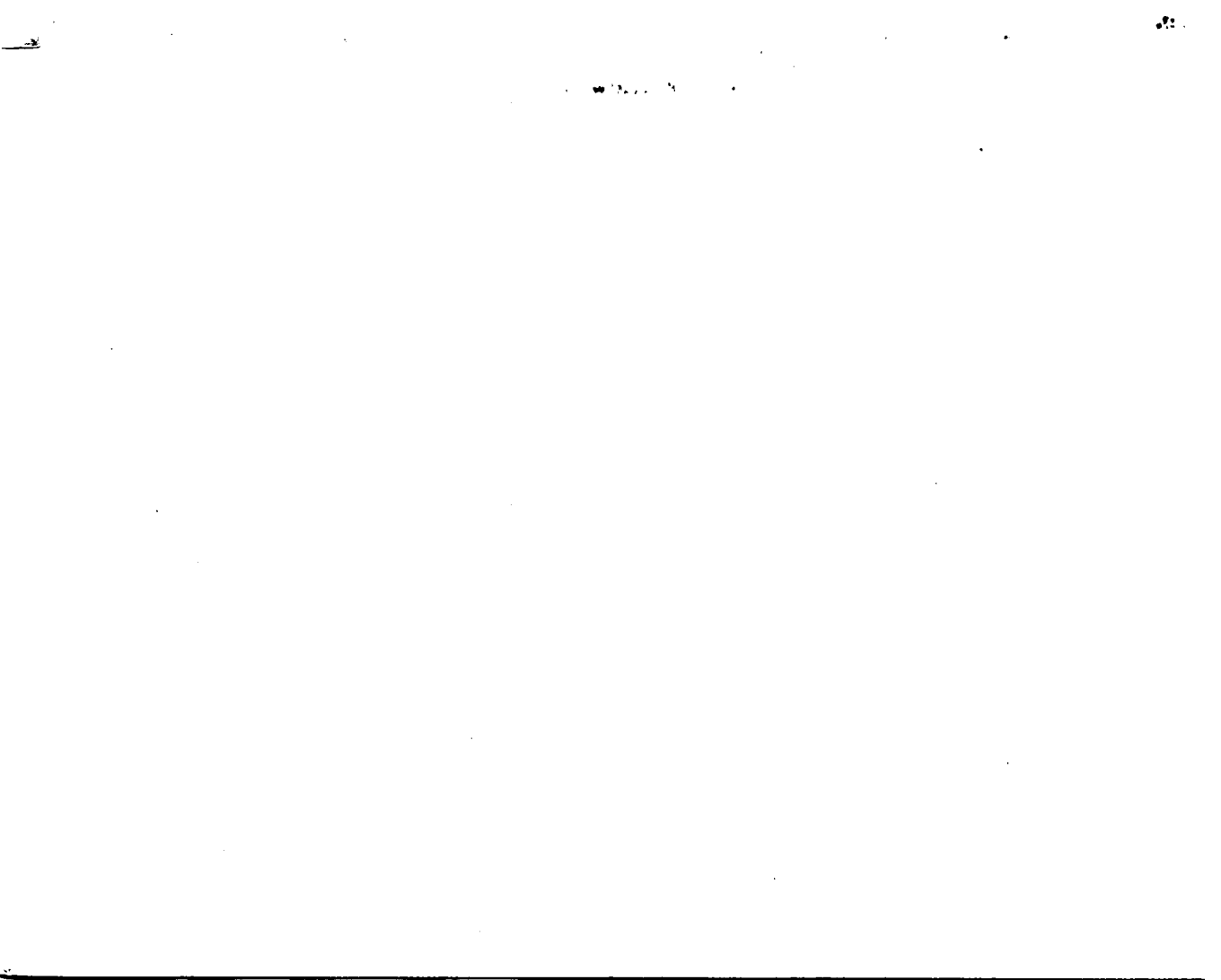
F. S. Wright M. D.

5

Selma

4/10 - 1927

Chio Bellamy



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

Lewis

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of

City of Nezperce

No. 993214 031 893

Registration District No.

State File No.

150515

Hospital

Primary Registration District No.

Local Registrar's No.

2129

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Child female

Twin
Triplet
or other?

-- } and {

Number
in order
of birth

Legitimate? Yes

Date of birth Jan 14

1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Alfred Nelson Richardson

RESIDENCE

Crofino Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

52

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Teamster in timber

FULL
MAIDEN
NAME

MOTHER

Mary Barbara Hill

RESIDENCE

Crofino Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

21

(Years)

BIRTHPLACE

Grangeville Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Born

9.25 A

I hereby certify that I attended the birth of this child, who was { Stillborn } at M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

P. E. Duce

(Physician or midwife)

Address

Craigmont Idaho

Filed

Jan 14 1927

Registrar.

Registrar.



10-10-68

1.

PLACE OF DEATH

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of

Registration District No.

60

2129

State File No.

56978

City of

Nezperce RFD

Primary Registration District No.

(No.

St.)

Local Registrar's No.

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Stillborn

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

fe

white

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

female

white

single

(Write the word)

6. DATE OF BIRTH

ch

14

927

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Nezperce Idaho RFD

10. NAME OF

Father

Alfred Nelson Richardson

11. BIRTHPLACE

OF FATHER

(State or Country)

Ill

12. MAIDEN NAME

OF MOTHER

Mary Barbara Hill

13. BIRTHPLACE

OF MOTHER

(State or Country)

Craneville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Nezperce RFD

15. ch 14,

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

ch

14

27

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
ch 14 1927 to ch 14 1927,
never

that I last saw her alive on --- 1927,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

P. E. Dumas

M. D.

5-14 1927

(Address)

Craigmont Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

Crofino Idaho

19. PLACE OF BURIAL OR REMOVAL

Hill Ranch

DATE OF BURIAL

ch 14 1927

20. UNDERTAKER

G. Hill

ADDRESS

Nezperce RFD

60

1

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

150571

County of *Minidoka*

City of *Paine*

No. *331713034281*

St. Registration

19

State File No.

Hospital

Primary Registrar

District No. *2013*

Local Registrar's No.

56

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

boy

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

3 13

1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Boric

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0

FULL NAME

FATHER

Rev. Clark

RESIDENCE

Paine

COLOR

White

AGE AT LAST BIRTHDAY

24
(Years)

BIRTHPLACE

Colo.

OCCUPATION

Labourer

FULL MAIDEN NAME

MOTHER

Mary Shaffer

RESIDENCE

Paine

COLOR

White

AGE AT LAST BIRTHDAY

18
(Years)

BIRTHPLACE

Colo.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was *Stillborn* at *8:15 P.* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1927

(Signature)

L. H. Kenney M.D.

(Physician or midwife)

Address

Reupert

Filed

4-24

1927

E. E. Edwards

Registrar.

Registrar

Handwritten signature and date: 1/15/61



100

Vertical text on the right margin, possibly a file number or reference code.

11

UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

NOTIFICATION OF BIRTH REGISTRATION

It is to advise you that there is preserved in the State office for the registration of statistics at BOISE, IDAHO, *a Record of Birth*

vs.:

me Clark *Sex* Male

born on March 15th, *1927*, *at* Paul, Idaho

name of father Rex Clark

maiden name of mother Mary Shafer


W. M. Stewart
Director of the Census.

Ralph M. Fouch M
Special Agent, Bureau of the Census

PLEASE PRESERVE CAREFULLY

IMPROVED NOTICE

The official record of birth of which this is a certificate is very valuable as proof of age and citizenship; it is necessary to have such proof in the future life of this child for the purpose of entering or leaving school, obtaining working papers or marriage license, inheriting property, holding public office, entering civil or military service, and for many other important objects.

NOTICE

If any errors are found in the statements given on the inclosed certificate, kindly send corrections at once to

DR. R. M. FOUCH,
Special Agent, Bureau of the Census,
Boise, Idaho.

Dr. R. M. Fouch will then take steps to make the necessary corrections of the records on file at the State office and at Washington, D. C.

PLEASE PRESERVE CAREFULLY

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Blaine

No. 655-17035-795 St.

Registration District No. 96

State File No. 150607

Hospital St. Joseph's

Primary Registration District No. 1009

Local Registrar's No. 150607

FULL NAME OF CHILD ✓

(Certificate of no value without full name of child)

Sex of Child M.

Twin
Triplet
or other? X

and { Number
in order
of birth X
(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of birth Mar 17 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive stillborn at 8 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

1927

Registrar.

Registrar.

1

2

3

4

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 13 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56996

County of Nez Perce.

Registration District No. 96

City of Lewiston.

Primary Registration District No. 1009

(No. St. Joseph Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Stillborn Wells

(a) Residence. No. St. Leips, Idaho.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male.

4 COLOR OR RACE

White.

5 Single, Married, Widowed,
or Divorced (write the word)

Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 3/17/27.

7 AGE Years Months Days If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work. None.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston, Idaho.
(State or country) Idaho.

10 NAME OF FATHER

R. L. Wells.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho.

12 MAIDEN NAME OF MOTHER

Mary L. Gregory.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho.

14 Informant R. L. Wells.
(Address) Leips, Idaho.

15 Filled Apr 11, 1927 Aaron E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 17th, 1927.
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from
March 17, 1927 to March 17, 1927

that I last saw him alive on March 17, 1927

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Stillborn fetus.

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) L. B. Kinsinger M. D.
3/19 1927 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Lewiston, Idaho. 3/17/27. 19

20. Undertaker Address

Broer-Jann Company. Lewiston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

213-118042-265
PLACE OF BIRTH
RECEIVED APR 7, 1927STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCounty of IdahoCity of Buhl

No. St.

Registration District No. 39 State File No. 150738

Hospital

Primary Registration District No. 2087 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>3-18</u> , 192 <u>7</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FULL NAME <u>Lewis Macalester</u>	FATHER	FULL MAIDEN NAME <u>Mamie Houicer</u>	MOTHER
RESIDENCE <u>Buhl</u>		RESIDENCE <u>Buhl</u>	
COLOR <u>WHL</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>WHL</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>North Dak.</u>		BIRTHPLACE <u>Neb</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>HW</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Idaho on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D. H. Jennings

(Physician or midwife)

Address Buhl, Ida.Filed 3-31 1927

Registral.

Registral.

RECEIVED APR 7 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of IdahoCity of BuhlRegistration District No. 39Primary Registration District No. 2087

(No. _____ St.)

File No. 57045

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvy Kaealer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

3-18-27
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country)

Buhl, Ida.

10. NAME OF FATHER

Lewis Kaealer

11. BIRTHPLACE OF FATHER

(State or Country)

North Dakota

12. MAIDEN NAME OF MOTHER

Mamie Kovacia

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lewis Kaealer

(Address)

Buhl, Ida.

15.

Filed 3-18 1927J. H. Murphy
Local Registrar

16. DATE OF DEATH

3-18-27
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-18-27 to 3-18-27that I last saw him alive on 3-18-27and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH was as follows:

Still Born - probably due to premature detachment of placenta.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ho. J. J. J.

M. D.

3-18-27 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Falls.3-18-27

20. UNDERTAKER

ADDRESS

Blue & Co.New Falls.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County Washington

City of Cambridge

No. 365-101044-695

St. Registration District No.

State File No.

150749

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD Lyford Love

(Certificate of no value without full name of child)

Sex of
Child Male

Twin
Triplet
or other? -

and {

Number
in order
of birth -

(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of
birth 4-1-

(Month)

(Day)

(Year) 1927

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

Vernon Love

RESIDENCE

Cambridge-Idaho 33

COLOR

White

AGE AT LAST
BIRTHDAY

(Years) 30

BIRTHPLACE

Utah

OCCUPATION

Rancher

FULL
MAIDEN
NAME

MOTHER

Jennie Winder

RESIDENCE

Cambridge-Idaho 32

COLOR

White

AGE AT LAST
BIRTHDAY

(Years) 32

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 8:00 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature) W. H. Bowman

(Physician or midwife)

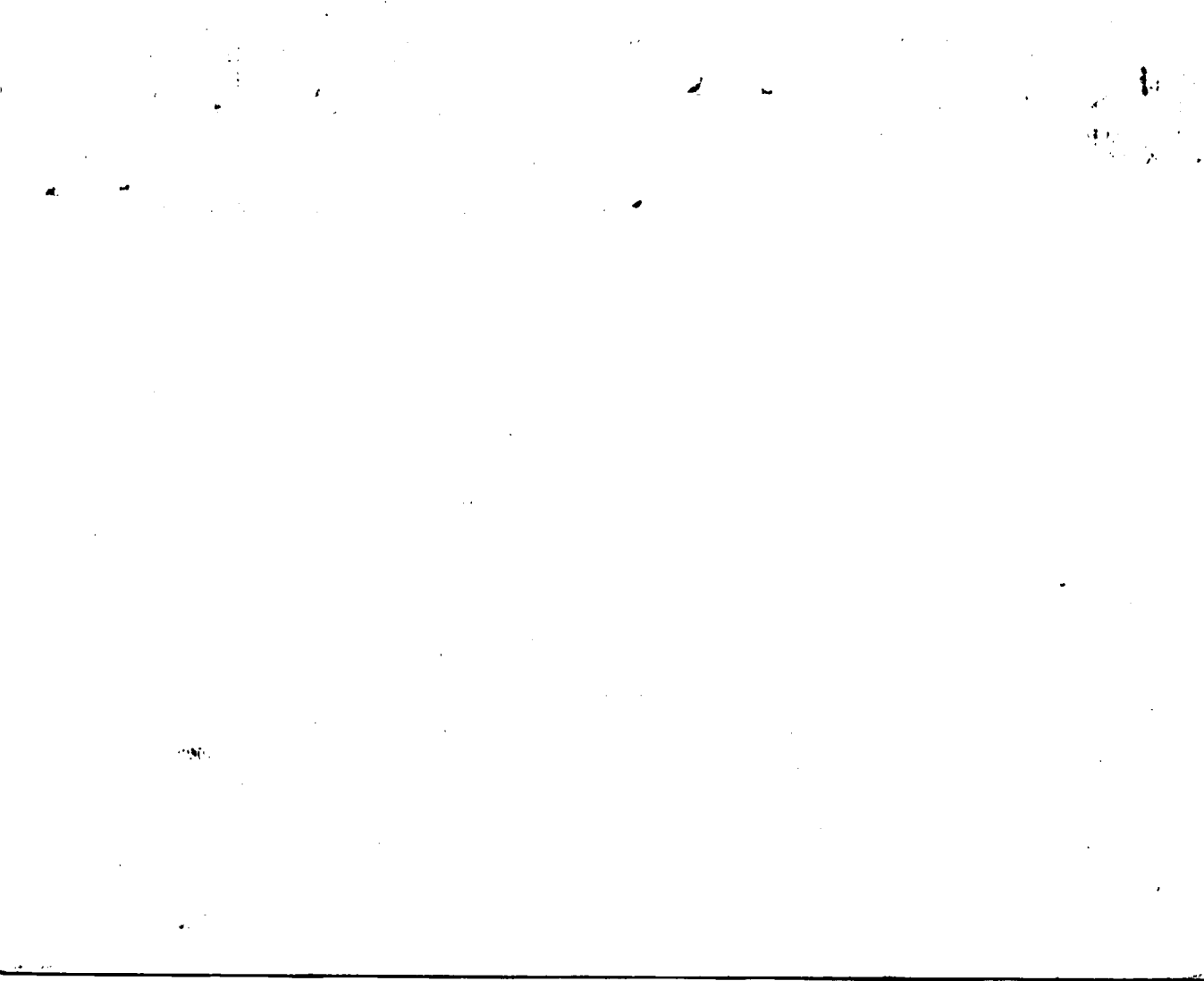
Address Cambridge-Idaho

Filed 4-4-

192

Registrar.

Registrar.



APR 18 1967

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 57325

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Washington Registration District No. _____
County of Adams Primary Registration District No. _____
City of Cambridge (No. _____, _____ St.

if death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Vernon Kohn

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WID- OWED OR DIVORCED.
Male	White	Single (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH. 4/3 1 127
(Month) (Day) (Year)

(Month) (Day) (Year)

7. AGE

..... Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
..... min.

that I last saw h. — alive on still born 191 —
and that death occurred on the date stated above, at — M. —

8. OCCUPATION

The CAUSE ~~OF~~ DEATH* was as follows:

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

CAUSE OF DEATH* was as follows:
Asphyxia Neonatorum.

9. BIRTHPLACE

(Duration) 1 hr 20 min 70 ds.
Contributory Paternal Placenta previa
(Secondary)

10. NAME OF FATHER

(Duration) 1 yrs. 1 mos. 0 ds.

**11. BIRTHPLACE
OF FATHER**

(Date) Nov 1958 yrs. mos. ds.
(Signed) W. H. H. H. H.
19 1958 (Address) Cambridge, Mass.

12. MAIDEN NAME OF MOTHER

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**13. BIRTHPLACE
OF MOTHER**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

(Informant) James Earl Ray
(Address) _____

Where was disease contracted
if not at place of death?.....

15. 4-11-29 191 New Haven

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

20. UNDERTAKER	ADDRESS
-----------------------	----------------

SYMS - YORK CO., PTRS. & NORM. 24854

Local Registrar

ADDRESS

ADDRESS
Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied: AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

275-130-001-694
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

RECEIVED MAY 5 1927

City of Burn

CERTIFICATE OF BIRTH

No. 1 St. Registration District No. 2 State File No. 150792

Hospital St. Luke's Primary Registration District No. 1004 Local Registrar's No. 128

FULL NAME OF CHILD Charles Spencer Jr.

(Certificate of no value without full name of child)

Sex of Child M Twin — Triplet — or other? — and { Number in order of birth 1 } Legiti- mate? yes Date of birth 9-30-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Born Net 1 To

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Charles Spencer
RESIDENCE Indian Cove Ada
COLOR Wn AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Texas
OCCUPATION Sheep - Wm

MOTHER
FULL MAIDEN NAME Helen. Cronsbey
RESIDENCE Indian Cove
COLOR Wn AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Cowa
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 6 PM on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Sumner M.D.
(Physician or midwife)

Address H-4
Filed 7 192 7 Paula M'Donell
Registrar. Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 5 1927 STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Ada

City of RA 4

No 609 127001 263 St.

Registration District No. 8 State File No. 150802

Hospital ✓

Primary Registration District No. 2008 Local Registrar's No. 25

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

M.

Twin
Triplet
or other

✓

and

Number
in order
of birth

✓

Legiti-
mate?

Yes

Date of
birth

4-27 1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER
C. L. Warthey

FULL
MAIDEN
NAME

MOTHER
Gladie, Bullock

RESIDENCE

Bonnie

RESIDENCE

RA 4

COLOR

Wh

AGE AT LAST
BIRTHDAY

31
(Years)

COLOR

Wh

AGE AT LAST
BIRTHDAY

24
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was 6' 10" A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Sutcliffe

(Physician or midwife)

Address

Filed

4-28

1927

Paula McKinnis

Registrar

Registrar

[illegible]

1. The first step in the process of identifying a problem is to define the problem. This involves identifying the symptoms of the problem and determining the scope of the problem. Once the problem has been defined, the next step is to identify the causes of the problem. This involves identifying the factors that are contributing to the problem and determining the root cause of the problem. Once the causes of the problem have been identified, the next step is to develop a plan to address the problem. This involves identifying the actions that need to be taken to address the problem and determining the resources that will be needed to implement the plan. Once a plan has been developed, the next step is to implement the plan. This involves carrying out the actions that have been identified in the plan and monitoring the progress of the implementation. Finally, the last step in the process is to evaluate the results of the implementation. This involves assessing the effectiveness of the plan and determining whether the problem has been resolved.

CONFIDENTIAL - FOR OFFICIAL USE ONLY (U) (S)

CONFIDENTIAL

the following table: *Journal of the American Medical Association*, 1971, 215: 100-101.

PHANTOM
MADAM
SMAN

204301238

RECEIVED
JAN 14 1964

ACKNOWLEDGMENTS

407,49,2550

CERTIFICATE OF ADOPTING PHYSICIAN OR MIDWIFE

I have written that I obtained the birth record of a child who was a twin.

...with the ...

...the ...

7471424M

02 CHITB

1996

RIGHT A-

MAV.

502346 12.75

4:7-8 :

AGE AT LAST
BIRTHDAY

ॐ नमो भगवते वासुदेवाय

00000000

RECEIVED MAY 5 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57063

PLACE OF DEATH

County of Ada
City of Boise

Registration District No.

Primary Registration District No.

Local Registrar's No. 24

(No. Boise Idaho, Route #2.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

m.

4. COLOR OR RACE

w.

5. Single, Married, Widowed,
or Divorced, (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

April 26-1927

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

Still Born.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Boise, Idaho.

10. NAME OF FATHER

Chester Worthy.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Alton Ill.

12. MAIDEN NAME OF MOTHER

Goldie Baldock.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Baker, Oregon.

14. Informant

(Address)

Pearl Allen.
Boise, Idaho.

15. Filed

4-28, 1927

Paula McDonald

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26, 1927

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 27, 1927

to Apr 27, 1927

that I last saw him alive on

and that death occurred, on the date stated above, at 6:11 m.

The CAUSE OF DEATH* was as follows:

Still Born.

No reason found.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

None

(duration) yrs. mos. ds.

18. Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

S. J. O'Leary

M. D.

4/27/27

(Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery.

4-27-27

20. Undertaker

Address

Wm McBratney

Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

867 106 003 689
PLACE OF BIRTH

RECEIVED APR 18 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

150848

County of Bannock

City of Bozeman

No. 806 N. Main St.

Registration District No. 28

File No. 150848

Hospital

Primary Registration District No. 2161

Registered No. 8113

FULL NAME OF CHILD

Joseph Henry Haggan

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>2-6-1927</u> (Month) (Day) (Year)
--------------------------	----------------------------------	-----	-----------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>James A. Haggan</u>	FULL MAIDEN NAME	<u>Mary Ellen Wheeler</u>
RESIDENCE	<u>806 N. Main</u>	RESIDENCE	<u>806 N. Main</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>England</u>
OCCUPATION	<u>master</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:45-9 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Haggan

(Physician or midwife)

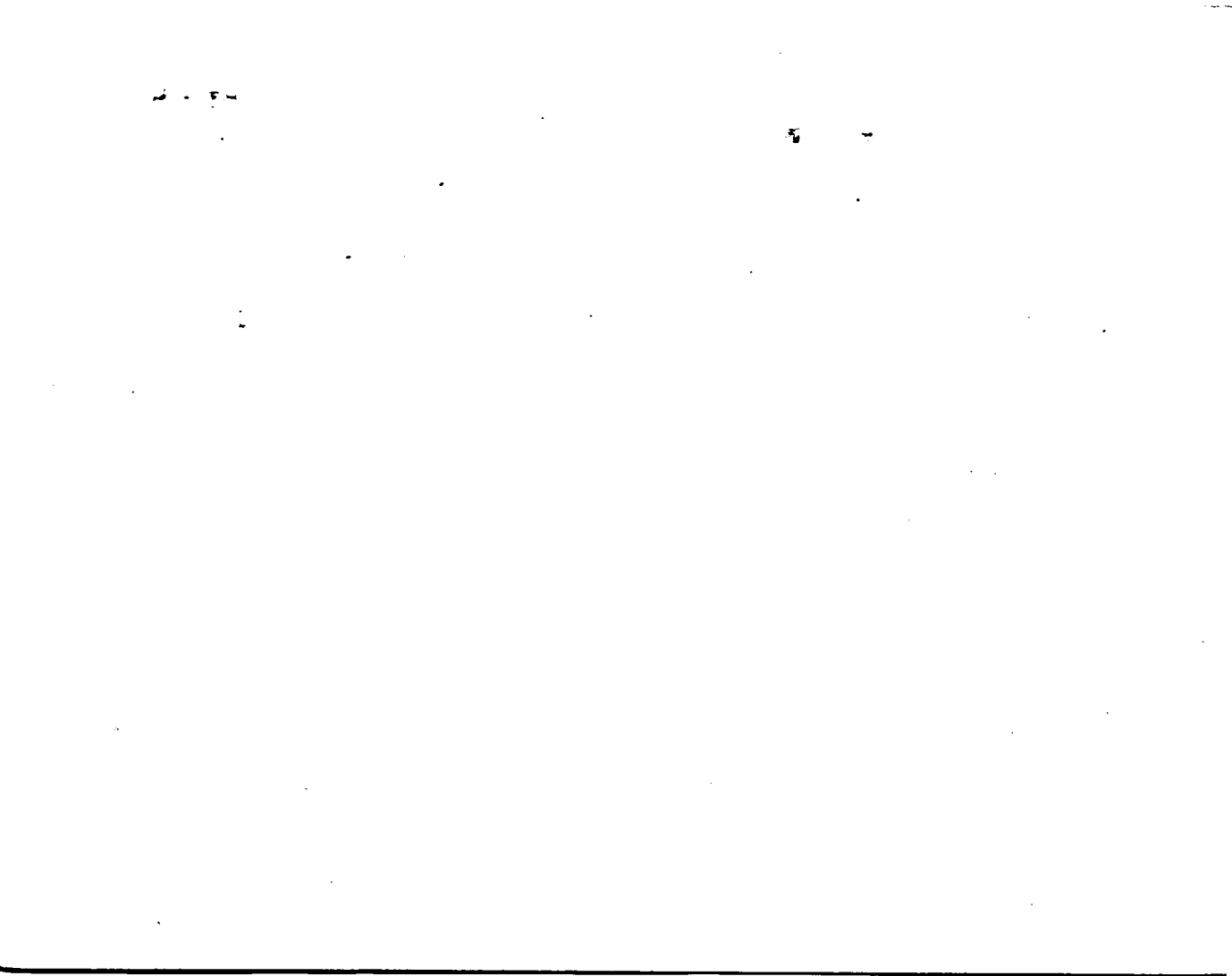
Give names added from a supplemental report.

Address 14020 Johnson

Filed 4/1 1927 J. H. Haggan

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 11 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56798

Local Registrar's No. 4985

PLACE OF DEATH

County of Barnum
City of Cozistille

Registration District No. 28

Primary Registration District No. 246

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Henry Hoggan

(a) Residence. No. 866 - North Main St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 6 - 1927

7 AGE

Years

Months

Days

If LESS than
1 day, hrs. min.

Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cozistille Idaho

10 NAME OF FATHER

J. A. Hoggan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ogden Utah

12 MAIDEN NAME OF MOTHER

Mary Helen Whitaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14 Informant

(Address)

J. A. Hoggan
Cozistille

15 Filled 2-7 1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb - 6
(Month)

(Day)

1927
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 6, 1927, to Feb 6, 1927

that I last saw him/her on road side 1927

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

J. W. Toman, M. D.
7/1/27 (Address) Cozistille

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Mountain View Bur Feb 7 1927

20. Undertaker

Address

Schumacher & Hall Cozistille

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 16 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear Lake

City of Hailey

No. 235 202 004964 St.

Registration District No. 52

State File No.

150905

Hospital

Primary Registration District No. 2136

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

4-2

1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

0

FULL
NAME

FATHER

Wm. Stephens

RESIDENCE

Hailey

COLOR

W

AGE AT LAST
BIRTHDAY

21
(Years)

BIRTHPLACE

Hailey

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Stress Rodock

RESIDENCE

Hailey

COLOR

W

AGE AT LAST
BIRTHDAY

19
(Years)

BIRTHPLACE

Hailey

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Hailey Idaho M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 1927

Registrar.

(Signature)

Wm. Stephens

(Physician or midwife)

Monkley, Idaho

Address

Filed

4-1-1927

Registrar.

(GEO) IN THE STATE OF ALABAMA, I, JAMES M. TAYLOR, being duly sworn, depose and say that the child named in the above certificate was born to the mother named in the above certificate on the day and date therein stated, and that the child was born to the mother named in the above certificate.

(Give names Address from a supplemental report.
 When there was no attending physician
 I submitted then the father's household
 record made this report. A statement
 is made that neither parent nor
 any other evidence of the child's birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive of white color, on the date above stated.

Address _____
 Signed _____
 (Physician or midwife)
 Registered _____

OCCUPATION _____
 BIRTHPLACE _____
 BIRTHDAY _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 RESIDENCE _____
 MOTHER'S NAME _____
 FATHER'S NAME _____

When attending solution was used in _____
 Name of child of this mother, including sex and birth _____
 Name of mother, including sex and birth _____
 Name of father, including sex and birth _____
 Name of child of this mother, including sex and birth _____
 Name of mother, including sex and birth _____
 Name of father, including sex and birth _____

FULL NAME OF CHILD _____
 Hospital _____
 No. _____
 City of _____
 County of _____
 PLACE OF BIRTH _____
 STATE OF ALABAMA
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH
 No. _____
 State File No. _____
 180000

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bear
City of Bloomington

No. 819-227004-713 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

150915

Registration District No. 63 State File No. 380

Prim. Registration District No. Local Registrar's No. 380

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate mate? <u>no</u>	Date of birth <u>april 27</u> <u>1927</u> (Month) (Day) (Year)
----------------------------	---	---	-------------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 10 (a) Born alive and now living 9

Born alive but now dead C Stillborn 1

FATHER FULL NAME <u>Lyons A. Hart</u>	MOTHER FULL MAIDEN NAME <u>Sarah E. Patterson</u>
--	--

Residence (Usual place of abode) Bloomington

If nonresident, give place and State

Color or race White Age at last Birthday 54 (Years)

Birthplace Idaho (City and State or Country)

Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2.45 P M.
on the date above stated.

(Signature) C. Moore M.D.

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address

Filed 6-30-27 Mrs. J. S. Skinner
Registrar.

... 1000 to 10000 in 1000 to 10000 self ...

shows other evidence of a well known child in the last nothing brother and etc. should have this return. A return of nothing from the latest homecoming, where there was no attending physician.

on the date above stated.

1. I have no other information to report.

(07072032)

(continued to next page)

22956A

1994年

OR, THAT, OR ALL, NO PHYSICIAN, OR MIDWIFE.

NOTES

(PENDING TO OTHER FILE 740)

and at last history

It is not possible to have a place and a date.

Headings (usual place of topics)

(1945)

Page 34 of 34

1952. The same day, 1952. 11

(State of Ohio) : ss. I, _____, Clerk of the Court of Common Pleas for the County of _____, do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of said Court.

RESULTS

THE NEW YORK PUBLIC LIBRARY

(a) _____ Born alive and now living

What pesticide was used to prevent outbreaks?

100-443888-100

NAME OF CHILD

(b)(7) - Exemption from "Freedom of Information Act" (FOIA)

10-3140

- 119 -

TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [REDACTED]

1944

2015

SECRET

DECLASSIFIED OF BIRTH

ESTIMATE TO LATE TO UAE

Registration District No. 140

Page 10

12 014

CONFIDENTIAL

10-4-68

to record

1950-1951

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
165-112-809-815
RECEIVED MAY 5 1927
County of Bonneville
City of Priest River

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 8.5 State File No. 150981
Hospital Priest River Primary Registration District No. 2185 Local Registrar's No. 24
FULL NAME OF CHILD Buddie Jones
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Apr. 12</u> 192 <u>7</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER		MOTHER	
FULL NAME <u>Warren P. Jones</u>	FULL MAIDEN NAME <u>Latta Nandy</u>		
RESIDENCE <u>Priest River</u>	RESIDENCE <u>Priest River</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Spokane, Wash.</u>	BIRTHPLACE <u>Atlanta, Georgia</u>		
OCCUPATION <u>Post master</u>	OCCUPATION <u>Lafayette wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn Some live at 6:15 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) E. E. Gifford M.D.

(Physician or midwife)

Address Priest River Idaho
Filed May 1 1927 E. E. Gifford Registrar.

Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 1 State File No. 1
Primary Registration District No. 1 Local Registrar's No. 1
Name of Child John Doe
Sex Male
Date of Birth Jan 1 1900
Place of Birth Chicago, Ill.
Parents' Names John Doe and John Doe
Maiden Name John Doe
Age at Last Birthday 1
Color White
Birthplace Chicago, Ill.
Occupation None

What antiseptics were used in case?
Number of child of this mother including present birth
Name of child of this mother including present birth
MOTHER
FULL NAME
MAIDEN NAME
RESIDENCE
COLOR
AGE AT LAST BIRTHDAY
BIRTHPLACE
OCCUPATION
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of the child, who was born at Chicago, Ill.
Signature of Physician or Midwife
Name of Physician or Midwife
Address of Physician or Midwife
Date of Birth Jan 1 1900
Place of Birth Chicago, Ill.
Name of Child John Doe
Sex Male
Age at Last Birthday 1
Color White
Birthplace Chicago, Ill.
Occupation None

When there was an attending physician or midwife, the father, householder, etc., should make this return. A signature of one that neither prescribes nor shows other evidence of the above birth. (This annex added from a supplemental report.)
Name of Child John Doe
Sex Male
Age at Last Birthday 1
Color White
Birthplace Chicago, Ill.
Occupation None
Signature of Registrar
Name of Registrar
Date of Birth Jan 1 1900
Place of Birth Chicago, Ill.
Name of Child John Doe
Sex Male
Age at Last Birthday 1
Color White
Birthplace Chicago, Ill.
Occupation None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **57155**

PLACE OF RECEIVED

CERTIFICATE OF DEATH

County of Bonner

Registration District No. 85

City of Priest River

Primary Registration District No. 2185

(No. Priest River Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Buddie Jones

(a) Residence. No. _____ St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 12, 1927

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Priest River
(State or country) Idaho

10 NAME OF FATHER

Warren P. Jones

11 BIRTHPLACE OF FATHER (city or town) Spokane
(State or country) Wash

12 MAIDEN NAME OF MOTHER

Lotta L. Handy

13 BIRTHPLACE OF MOTHER (city or town) Savanna,
(State or country) Ga.

14 Informant Warren P. Jones
(Address) Priest River Idaho

15 Filed May 1, 1927

E. E. Gutzloff
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 12, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased April 12, 1927 to April 12, 1927 that I last saw him alive on April 12, 1927 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Very large causing difficult labor possible injury to neck and ligaments.
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) E. E. Gutzloff M.D.

April 12, 1927 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

I. O. O. F. Cemetery Apr. 12, 1927

20. Undertaker

Address

R. E. Wessa Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

465-121-009-639
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of B ~~PREPARED~~ MAY 6 1927City of Sandpoint

CERTIFICATE OF BIRTH

150986

No. St. Registration District No. 78 State File No.Hospital Primary Registration District No. 2155 Local Registrar's No.FULL NAME OF CHILD Stillborn Montgomery

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>April 1</u> 192 <u>7</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER

FULL NAME Errol Montgomery

RESIDENCE Sandpoint, Ida.

COLOR White AGE AT LAST BIRTHDAY 38 (Years)

BIRTHPLACE N. Dakota

OCCUPATION Laborer

MOTHER

FULL MAIDEN NAME Elba M. Flint

RESIDENCE Sandpoint, Ida.

COLOR White AGE AT LAST BIRTHDAY 38 (Years)

BIRTHPLACE Missouri

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. E. Alcorn M.D.

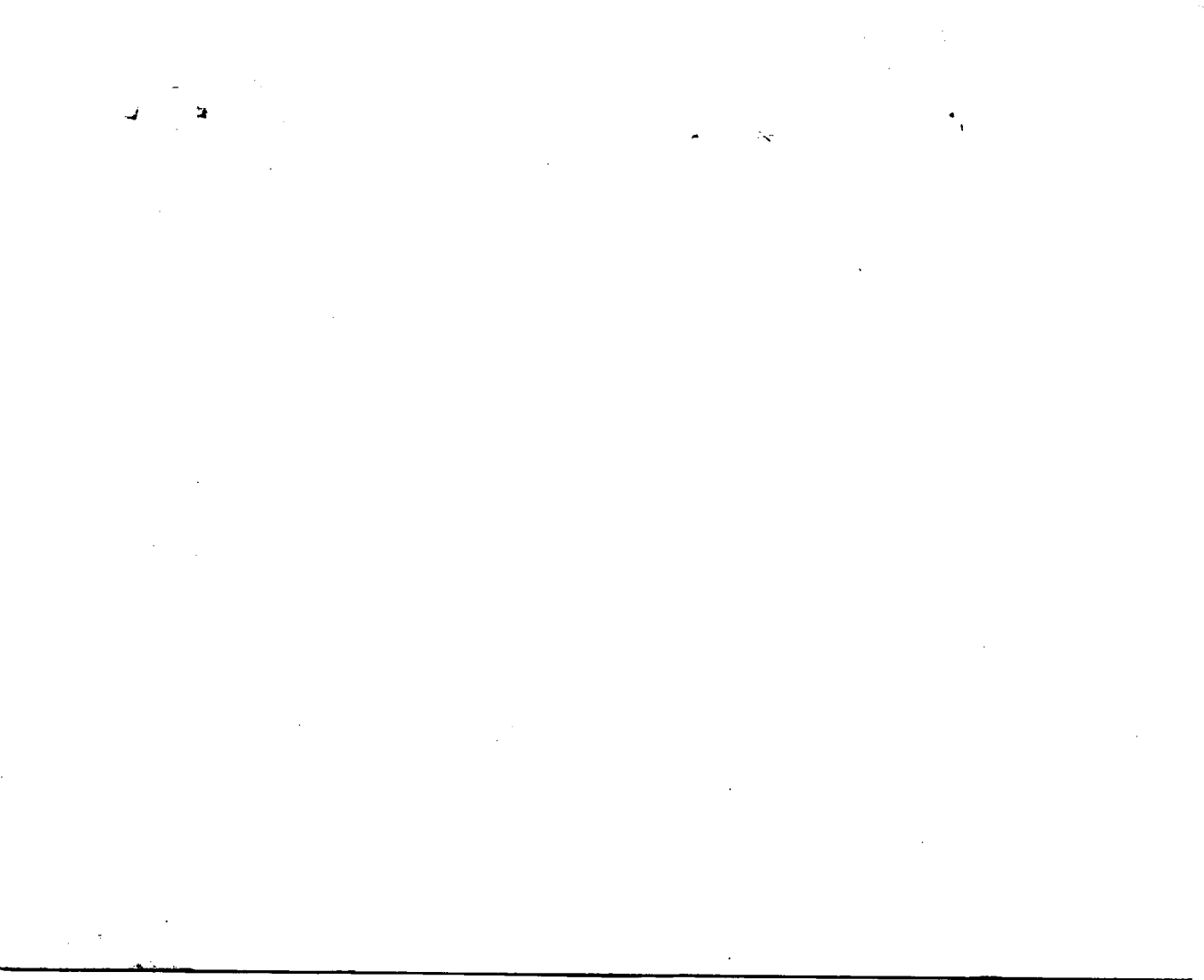
(Physician or midwife)

Address Sandpoint, Ida.Filed May 3 1927 Viola Allen

Deputy Registrar

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 6 1927

PLACE OF DEATH

County of Bonner.

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 77

Primary Registration District No. 2155

(No.)
(If death occurred in a hospital institution, give its name instead of street and number.)

2. FULL NAME Stielborn Montgomery

(a) Residence. No. St.

(Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Stielborn

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint (State or country) Idaho.

10. NAME OF FATHER Eoval Montgomery

11. BIRTHPLACE OF FATHER (city or town) N. Dakota (State or Country)

12. MAIDEN NAME OF MOTHER Ella M. Flint

13. BIRTHPLACE OF MOTHER (city or town) Missouri (State or Country)

14. Informant Eoval Montgomery (Address) 921 Poplar St. Sandpoint, Idaho

15. Filed April 2, 1927 Viold Allen Registrar Deputy

DO NOT WRITE IN THIS SPACE

State File No. 57150

Local Registrar's No.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stielborn April 1, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1927, to 4-1, 1927, that I last saw him alive on 4-1, 1927, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stielborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Cleaves M. D. 4-1, 1927 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery Date of Burial Apr. 2, 1927

20. Undertaker L. B. Moon Address Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

863-118-009-714
PLACE OF BIRTH

RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Kootenai

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 78 State File No. 151002

Hospital Hemo Primary Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Carl Helmgren

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	} and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>April 18</u> 19 <u>27</u> (Month) (Day) (Year)
-----------------------------	---	---	--------------------------------	--

What bactericidal solution was used in eyes? x

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Carl Helmgren
RESIDENCE Kootenai
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Sweden
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Shella Paulson
RESIDENCE Kootenai
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Norway
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

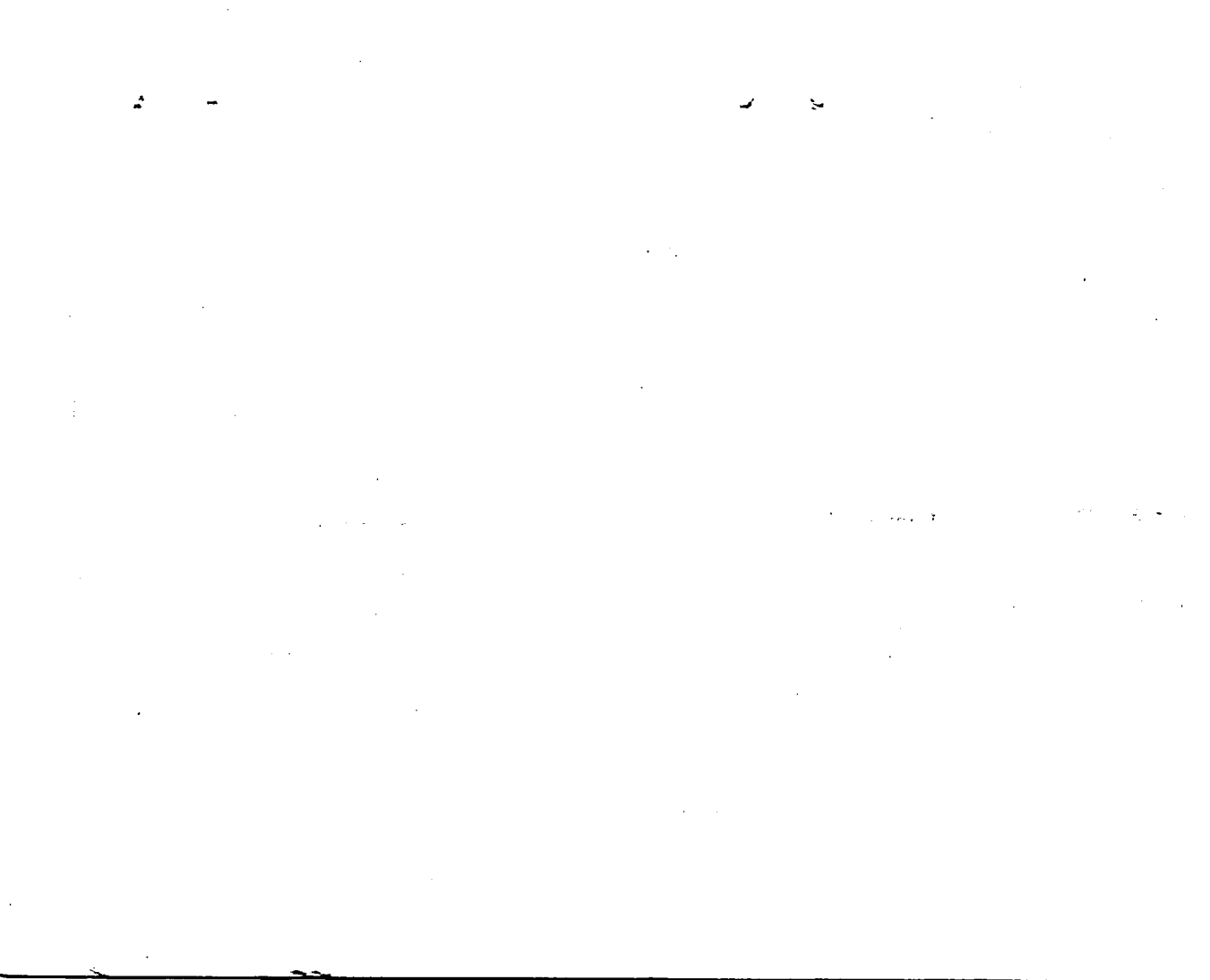
(Signature) Kueford D. Ross
(Physician or midwife)

Address Sandpoint, Idaho

Filed May 3 1927

Registrar.

Viola Allen
Deputy Registrar.



RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57144

PLACE OF DEATH
County of Bonner
City of SandpointRegistration District No. 78
Primary Registration District No. 2155

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Infant Hobmgren.

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) April 18, 19277. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillbirth

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint Idaho
(State or country)10. NAME OF FATHER Chas. Hobmgren.11. BIRTHPLACE OF FATHER (city or town) Sweden
(State or Country)12. MAIDEN NAME OF MOTHER Shella Paulson13. BIRTHPLACE OF MOTHER (city or town) Norway
(State or Country)14. Informant Chas. Hobmgren
(Address) Post Office, Idaho.15. Filed April 19, 1927
Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Stillbirth
April 18, 1927.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn. Death due to
difficult labor.
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Rosford J. Ross. M. D.
Apr. 19, 1927 (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pingree Cemetery Date of Burial April 19, 1927.20. Undertaker A. S. Moon. Address Sandpoint, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

362-129011-134
PLACE OF BIRTH

RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of..... Boundary.....

CERTIFICATE OF BIRTH

151025

No..... St. Registration District No. 79..... State File No. 2156

Hospital..... Primary Registration District No..... Local Registrar's No.....

FULL NAME OF CHILD Baby Cossiart
(Certificate of no value without full name of child)

Sex of Child	Male	Twin Triplet or other?	and { Number in order of birth	Legiti- mate? Yes	Date of birth	Mar. 29 7 1927
					(Month)	(Day) (Year)

What bactericidal solution was used in eyes? 1% AGNO₃

Number of child of this mother, including present birth. 2 Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME Cecil H. Cossiart
RESIDENCE Naples Ida.
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Mont.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Carol W. Aldridge
RESIDENCE Naples Ida.
COLOR White AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Okla.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

(Signature) *E. E. Ing*
Physician
(Physician or midwife)

Address Bonners Ferry, Ida.

Filed Mar. 29 1927. *E. E. Ing*
Registrar.

100

100

100

100

100

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57177

County of Boundary
City of Bonners Ferry

Registration District No. 29
Primary Registration District No. 2156
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Babey Cossaint

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Mar. 29-27

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. _____ min. Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Bonners Ferry
(State or country) Idaho

10 NAME OF FATHER Cecil Cossaint

11 BIRTHPLACE OF FATHER (city or town) Mont
(State or country) _____

12 MAIDEN NAME OF MOTHER Carrol Aldridge

13 BIRTHPLACE OF MOTHER (city or town) Oklahoma
(State or country) _____

14 Informant Mrs G E Aldridge
(Address) Bonners Ferry

15 Filled Mar. 29, 1927 E E King
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Stillborn
Asphyxia (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY difficult breech delivery
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) E E King M. D.
Mar. 29 1927 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Bonners Ferry Date of Burial Mar 29 1927

20. Undertaker H R Crouch, Bonners Ferry
Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

366-126 014-253
PLACE OF BIRTH

RECEIVED MAY 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Canyon
City of Nampa
No. 126-13 avh St. Registration District No. _____ State File No. 151065
Hospital _____ Primary Registration District No. 006 Local Registrar's No. 353
FULL NAME OF CHILD Charles Lawlis

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth Apr 26 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? not put in

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Howard Lawlis
RESIDENCE Nampa
COLOR Wht AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Nebraska
OCCUPATION Sheepman

MOTHER
FULL MAIDEN NAME Marguerite Betts
RESIDENCE Nampa
COLOR Wht AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE France
OCCUPATION sewer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

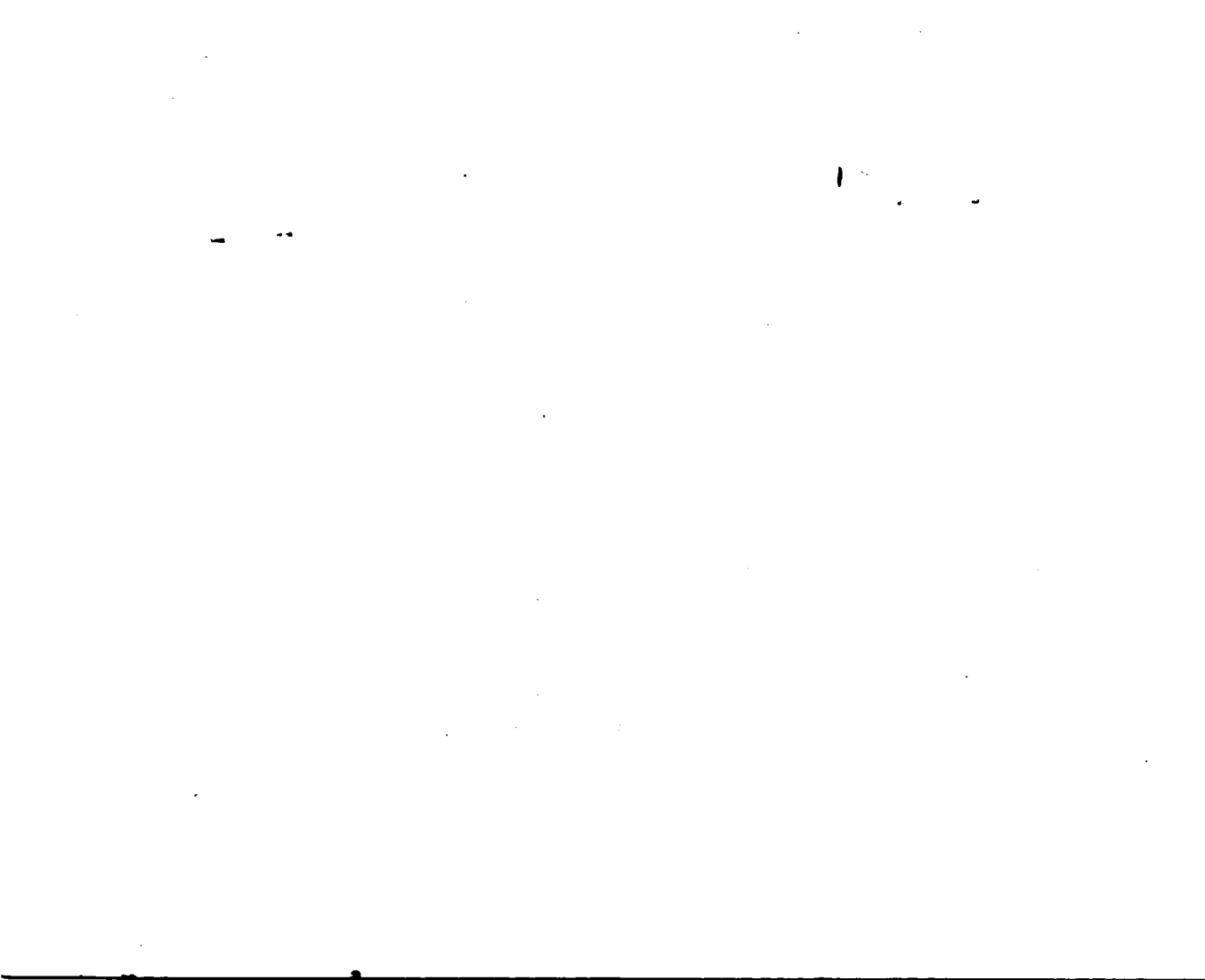
I hereby certify that I attended the birth of this child, who was born at 6: P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Geo. K. Proctor
(Physician or midwife)

Address Nampa
Filed 5-4 1927 Mar 5 Terby
Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57186

County of CampanCity of NampaRegistration District No. 1Primary Registration District No. 1006(No. 124-15 300 11)Local Registrar's No. 234

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Lawrence(a) Residence. No. 5 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of6. DATE OF BIRTH (month, day and year) 4-26-277. AGE Years Months Days If LESS than 1 day, hrs. or min.
4 26 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa Idaho
(State or country)10. NAME OF FATHER Howard Edwin11. BIRTHPLACE OF FATHER (city or town) Nampa Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Josephine Belts13. BIRTHPLACE OF MOTHER (city or town) France
(State or Country)14. Informant Howard Edwin
(Address) Nampa Idaho15. Filed 5-5, 1927 Maesterby
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 26 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 1927, to Apr 26, 1927
that I last saw him alive on Apr 26, 1927and that death occurred, on the date stated above, at appt 6 PM
The CAUSE OF DEATH* was as follows: Dystocia (fetal)
(death at time of delivery)CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Geo R. Proctor, D.
4-27-27 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Nampa Idaho 4-27 1927

20. Undertaker Address

Franklin Nampa Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin
City of Preston, Ida

CERTIFICATE OF BIRTH 151148

No 863 203021262 St. Registration District No. 27 State File No.

Hospital Primary Registration District No. 2117 Local Registrar's No. 83

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child	<u>Female</u>	Twin Triplet or other?	and { Number in order of birth	Legiti- mate?	<u>yes</u>	Date of birth	<u>Apr. 3</u>	<u>1927</u>
			(To be answered only in event of plural births)			(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Lyman Hollingsworth
RESIDENCE Preston, Ida
COLOR White AGE AT LAST BIRTHDAY 10 (Years)
BIRTHPLACE Preston, Ida
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Leora Bosen
RESIDENCE Preston, Ida
COLOR White AGE AT LAST BIRTHDAY 17 (Years)
BIRTHPLACE Riverdale, Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3-10 A- M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192

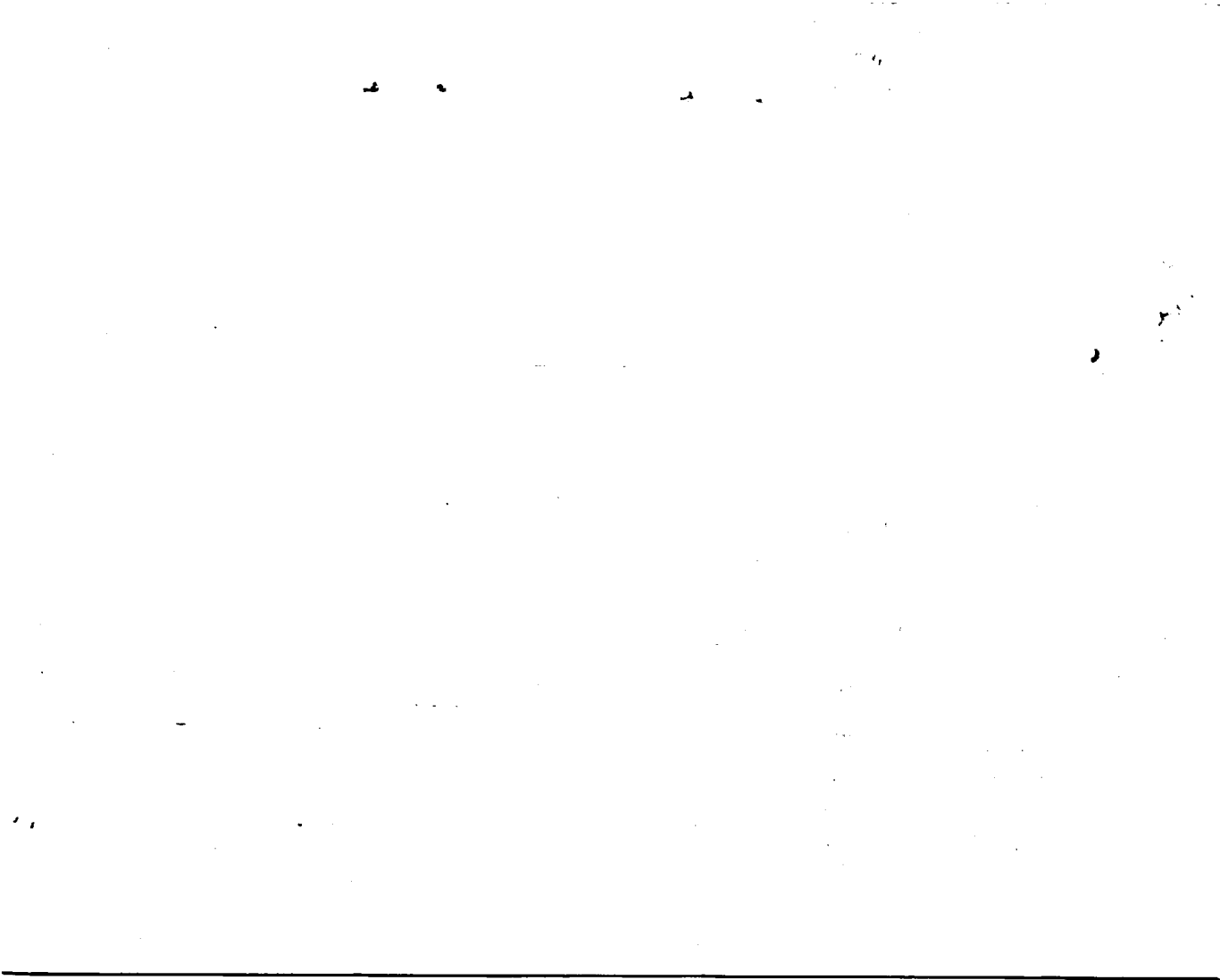
(Signature) G. W. Stiles
M. D.
(Physician or midwife)

Address Preston, Ida

Filed May 5 1927

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PRECISELY, and in full. STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of age, sex, date and place of birth, and date and place of death, are very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19		STATE OF IDAHO	
RECEIVED MAY 6 1927		DEPARTMENT OF PUBLIC WELFARE	
BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS	
1. PLACE OF DEATH		27	
County of <u>Franklin</u>		Registration District No. <u>2119</u>	
City of <u>Wilder</u>		Primary Registration District No. <u>2119</u>	
If death occurs away from usual residence, give facts called for under special information.		(No. <u>2119</u> St.)	
2. FULL NAME <u>Hollingsworth, Stillborn</u>		Local Registrar's No. <u>22</u>	
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>Female</u>		16. DATE OF DEATH <u>Apr 3 1927</u>	
4. COLOR OR RACE <u>White</u>		(Month) (Day) (Year)	
5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>			
6. DATE OF BIRTH <u>April 3 1927</u>		17. I HEREBY CERTIFY, That I attended deceased from <u>Apr 3 1927</u> to <u>Apr 3 1927</u>	
(Month) (Day) (Year)		that I last saw him alive on <u>Apr 3 1927</u>	
7. AGE <u>A Still Born Child</u>		and that death occurred on the date stated above, at <u>1927</u>	
IF LESS than 1 day how many hrs. or min.?		The CAUSE OF DEATH* was as follows: <u>Premature child dead at birth - Born before my approval - Had been diagnosed by doctor prior to birth</u>	
8. OCCUPATION		(Duration) yrs. mos. ds.	
(a) Trade, profession or particular kind of work		Contributory (Secondary)	
(b) General nature of industry, business or establishment in which employed (or employer)		(Duration) yrs. mos. ds.	
9. BIRTHPLACE <u>Franklin Co Idaho</u>		(Signed) <u>J. W. States M. D.</u>	
(State or Country)		(Address) <u>Boise Idaho</u>	
10. NAME OF FATHER <u>Lyman Hollingsworth</u>		*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
11. BIRTHPLACE OF FATHER <u>Greston Idaho</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)	
(State or Country)		At place In the	
12. MAIDEN NAME OF MOTHER <u>Leona Bowen</u>		of death yrs. mos. days. State yrs. mos. ds.	
13. BIRTHPLACE OF MOTHER <u>Riverdale Idaho</u>		Where was disease contracted	
(State or Country)		if not at place of death?	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		Former or usual residence	
(Informant) <u>J. W. States</u>		19. PLACE OF BURIAL OR REMOVAL	
(Address) <u>Boise Idaho</u>		DATE OF BURIAL	
15. Filed <u>May 3 1927</u> <u>A. R. Custer</u>		20. UNDERTAKER	
Local Registrar		ADDRESS	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH County of <u>Idaho</u> City of <u>Cottonwood</u>		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S
No. <u>212-118025-356</u> St. (If born in hospital or institution give name.)		CERTIFICATE OF BIRTH Registration District No. <u>105</u> State File No. <u>151185</u> Prim. Registration District No. <u>2183</u> Local Registrar's No. <u>34</u>		
FULL NAME OF CHILD <u>Harvey Baker</u> (If stillborn, substitute the word "Stillbirth" for name of child)				
Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 18</u> 19 <u>27</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____				
Number of child of this mother, including present birth <u>5</u> (a) Born alive and now living <u>2</u>				
Born alive but now dead _____ Stillborn _____				
FULL NAME <u>Geo. H. Baker</u>		FULL MAIDEN NAME <u>Mabel E. Jeff</u>		
Residence (Usual place of abode) <u>Cottonwood, Id.</u>		Residence (Usual place of abode) <u>Cottonwood, Id.</u>		
If nonresident, give place and State _____				
Color or race <u>W.</u> Age at last Birthday <u>54</u> (Years)		Color or race <u>W.</u> Age at last Birthday <u>34</u> (Years)		
Birthplace <u>Carthage, Mo.</u> (City and State or Country)		Birthplace <u>Keyterville, Ida.</u> (City and State or Country)		
Occupation <u>Stockman</u>		Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9 A. M.
on the date above stated. { Stillborn }

(Signature) Messrs F Orr M.D.

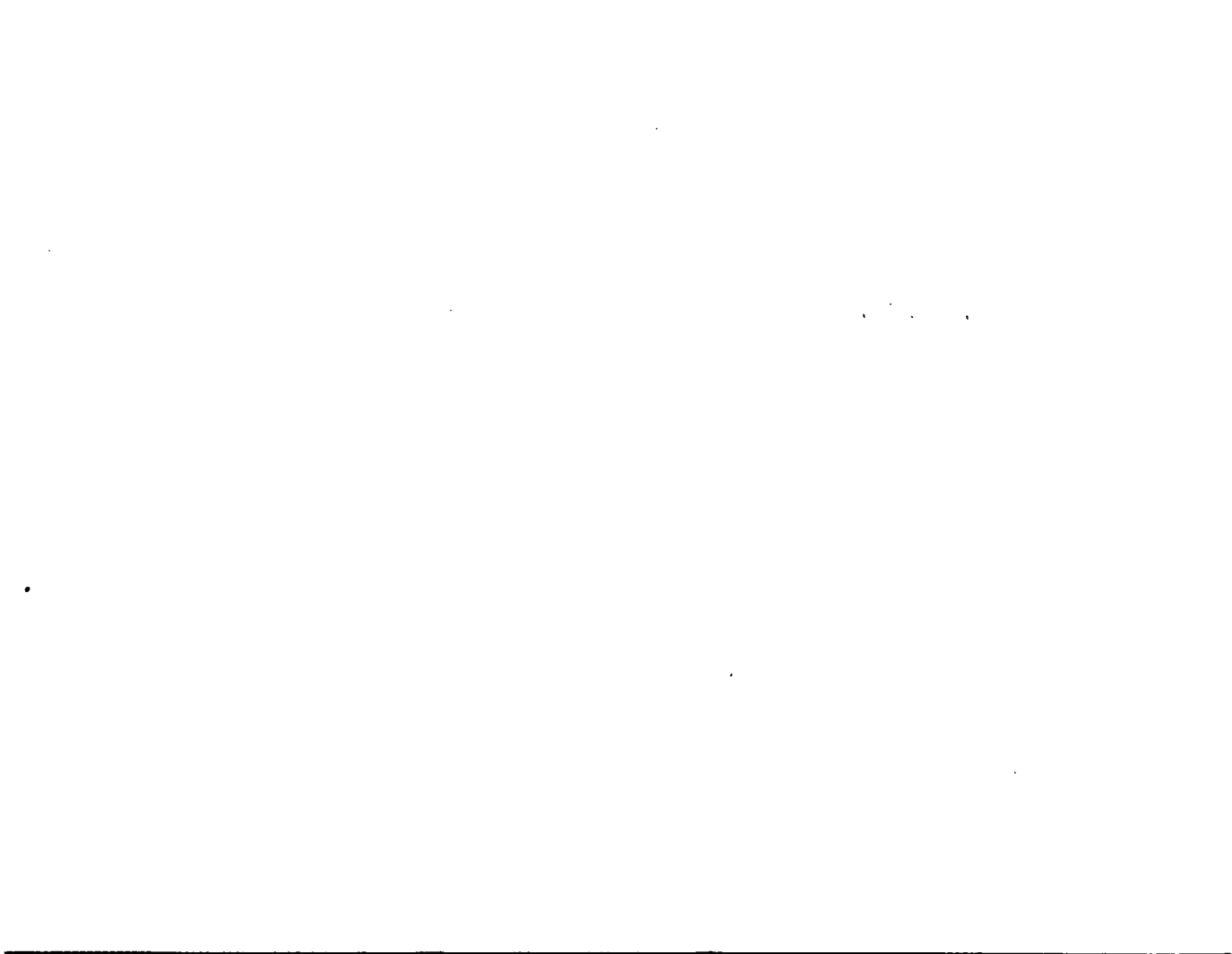
(Physician or midwife)

Address Cottonwood, Ida.

Filed May 2 1927 H. F. Orr per 9.15

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



PLACE OF BIRTH

STATE OF IDAHO

RECEIVED APR 25 1927

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai

City of _____

CERTIFICATE OF BIRTH

No. 219-22028 219 St. Registration District No. _____ State File No. 151210Hospital _____ Primary Registration District No. _____ Local Registration District No. 151210FULL NAME OF CHILD (unnamed) Barden

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>March 22, 1927</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Henry Barden</u>	FULL MAIDEN NAME	<u>Leare M. Bailey</u>
RESIDENCE	<u>Post Falls, Ida. R. 1</u>	RESIDENCE	<u>Post Falls - Ida. R. 1</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>29</u> (Years)	AGE AT LAST BIRTHDAY	<u>16</u> (Years)
BIRTHPLACE	<u>Mont.</u>	BIRTHPLACE	<u>Mont.</u>
OCCUPATION	<u>laborer</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6.45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Frank Henry

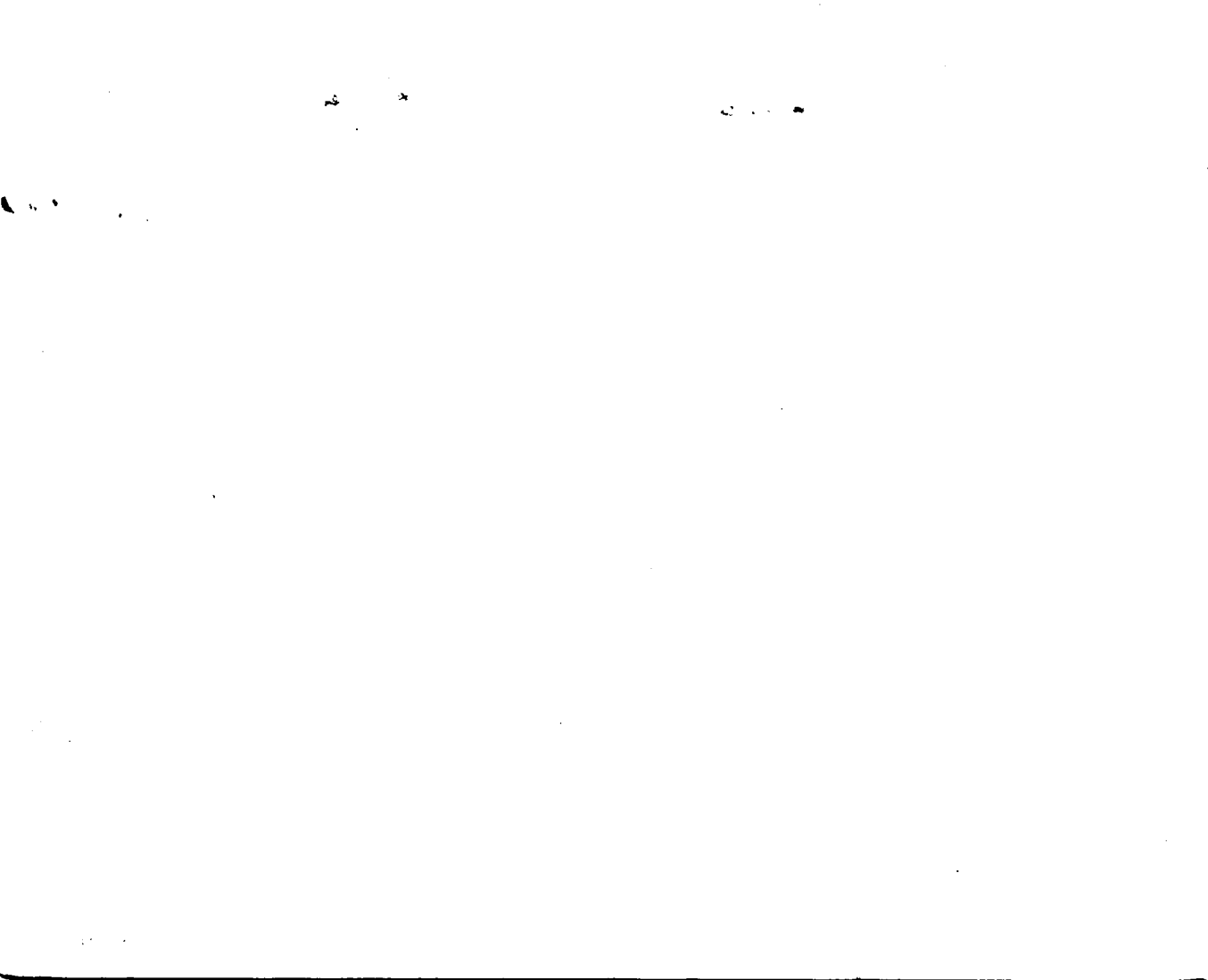
(Physician or midwife)

Address Post Falls, Ida.Filed 4/8 1927 S. D. Branan

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

57259

Local Registrar's No.

County of Post Falls

Registration District No.

City of

Primary Registration District No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (unusually) Bardon

(a) Residence. No. _____ St. Post Falls - Idaho. R.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) stillborn

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Post Falls - Idaho
(State or country)

10 NAME OF FATHER Henry Bardon

11 BIRTHPLACE OF FATHER (city or town) (Mont.)
(State or country)

12 MAIDEN NAME OF MOTHER Pearl M. Bailey

13 BIRTHPLACE OF MOTHER (city or town) (Mont.)
(State or country)

14 Informant Henry Bardon
(Address) Post Falls - Idaho

15 Filed 3/23, 1927 Ed A. Sherman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 22, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1927, to March 22, 1927.

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

stillborn - macerated -
cranial bones only partially
developed -
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY 6 1/2 month gestation
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Frank Hays, M. D.
3/23, 1927 (Address) Post Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Post Falls - Rathdum Date of Burial 3/23 1927

20. Undertaker Carey Funeral Home Address Rathdum

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

151240
S

County of Latah

City of Troy

No. 791725009636 St.

Registration District No. 64

State File No.

Hospital

Primary Registration District No. 2144

Local Registrar's No.

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

4-25

1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Just Graubard

RESIDENCE

Troy, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

Troy, Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Ebba Flodin

RESIDENCE

Troy, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

32
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4:30 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

April 30, 1927
Lucy M. Pickard
Registrar.

(Signature)

Chas. G. Meyer
Physician
(Physician or midwife)

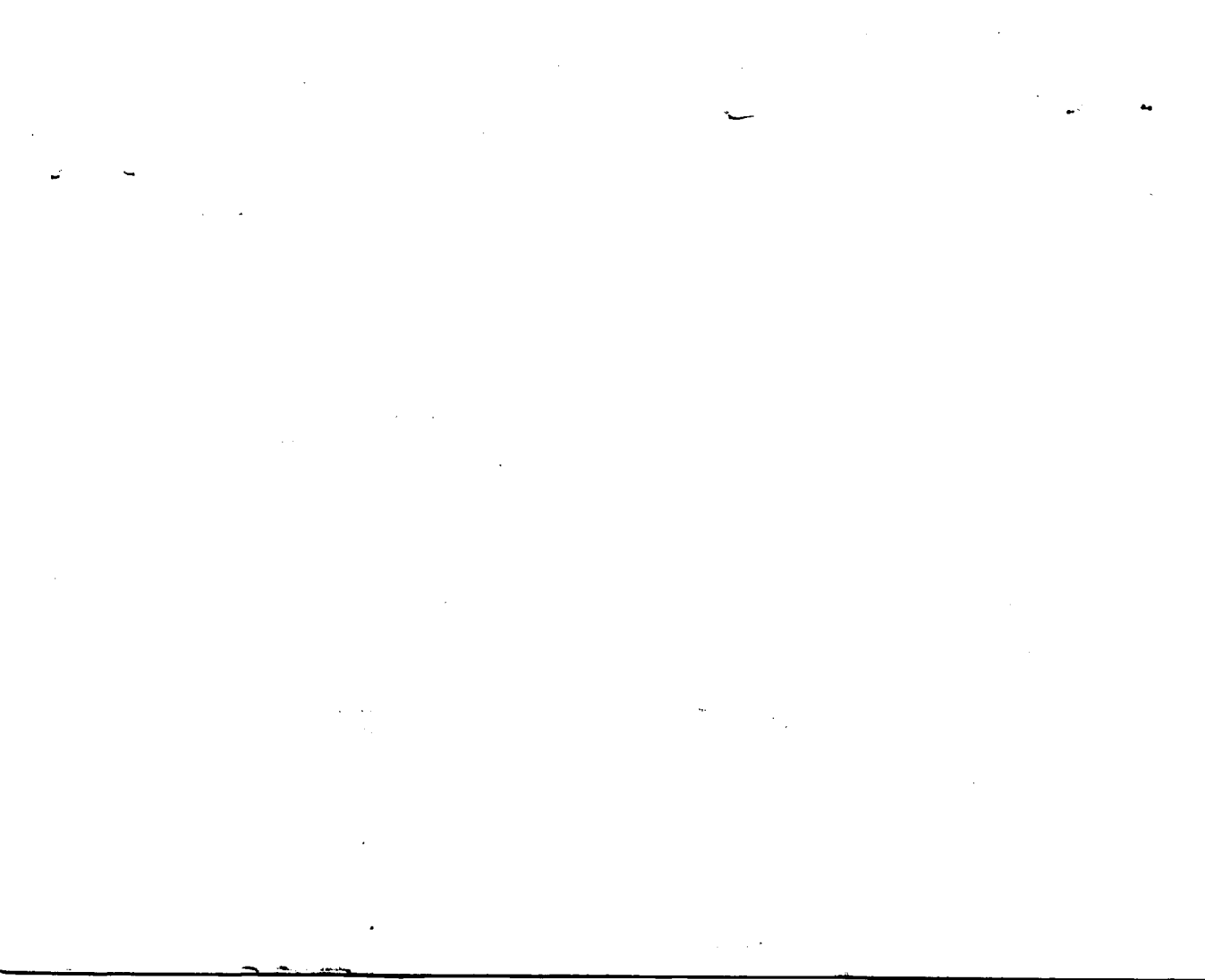
Address

Troy, Idaho

Filed

April 30, 1927

Lucy M. Pickard
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 57270

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Salah

Registration District No.

Local Registrar's No.

City of Troy

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 25 - 1927

7 AGE

Years

Months

Days

If LESS than 1 day or 0 min. hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Troy, Idaho
(State or country)

10 NAME OF FATHER Josh Paulund

11 BIRTHPLACE OF FATHER (city or town) Troy, Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Emma Rodin

13 BIRTHPLACE OF MOTHER (city or town) Troy, Idaho
(State or country)

14 Informant Josh Paulund
(Address) Troy, Idaho

15 Filed April 30, 1927 Lucy M. Pickard
Registrar

16 DATE OF DEATH

April 25
(Month) (Day)

1927
(Year)

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1927 to April 25, 1927

that last saw him alive on April 25, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Meyer M. D.
Apr. 25, 1927 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

None

April 26, 1927

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

133-213 035-263

PLACE OF BIRTH

RECEIVED APR 22 1927

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Ney

CERTIFICATE OF BIRTH

City of SpaldingRegistration District No. 128File No. 151269

No. _____ St. _____

Hospital _____

Primary Registration District No. 128

Registered No. _____

FULL NAME OF CHILD John AllegierSex of Child femaleTwin
Triplet
or other?
(To be answered only in event of plural births)and Number
in order
of birth
(To be answered only in event of plural births)Legiti
mate?Date of
BirthJan 13 1927
(Month) (Day) (Year)FULL
NAMEBert Arthur Allegier

RESIDENCE

Spalding, Idaho.

COLOR

whiteAGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

Washington

OCCUPATION

FarmerFULL
MAIDEN
NAMELucia Bolen

RESIDENCE

Spalding Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY33
(Years)

BIRTHPLACE

Idaho

OCCUPATION

(7 months baby) HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born, at 12 P.M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature)

Geo B. Keck M.D.
Physician, Lapwai, Idaho,
(Physician or midwife)

Address _____

Filed Jan 27

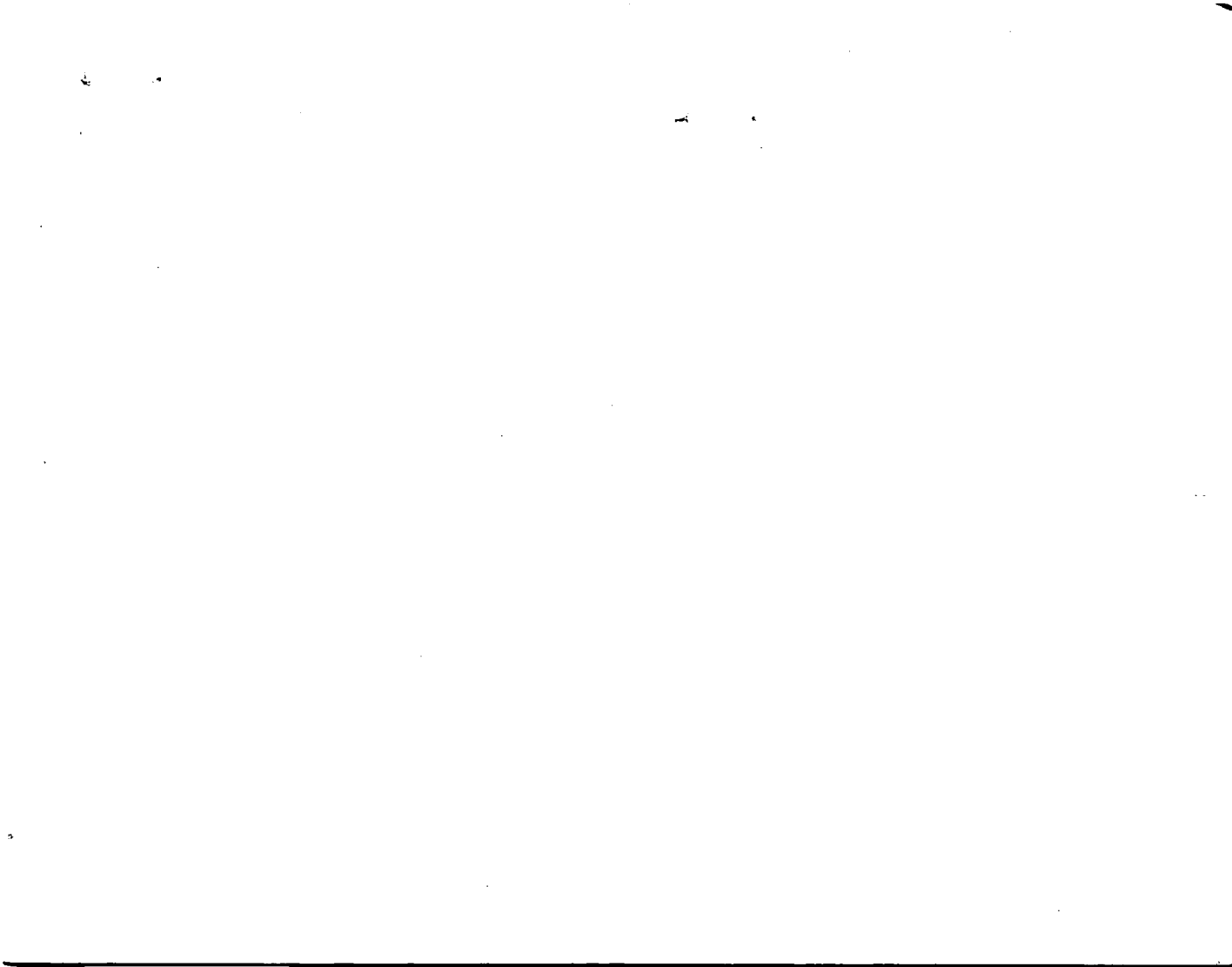
19

George Gagnard M.D.
RegistrarCause of still born child unknown.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Spalding*
County of *Idaho*
City of *Spalding*
Registration District No. _____
Primary Registration District No. _____
(No. _____ St.)

File No. *57287*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Jean**Alligier*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH

Jan 13 1927
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Spalding, Idaho

10. NAME OF FATHER

Bert. Arctus Alligier

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lucira Bolen

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Geo O Keck
Lapwai, Idaho.

15.

Filed _____ 191 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 13 1927 to Jan 13 1927

that I last saw him alive on _____ 191 _____
and that death occurred on the date stated above, at *12:15 P.M.*

The CAUSE OF DEATH was as follows:

Still Born (Cause unknown)
(7 term month baby)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Cause unknown

(Duration) Yrs. mos. ds.

(Signed) *Geo O Keck* M. D.

1/13 27 (Address) *Lapwai, Idaho.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spalding Idaho *1/13 1927*

20. UNDERTAKER

ADDRESS

Family *Spalding, Ida.*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

695710-236-819
PLACE OF BIRTH

RECEIVED MAY 4 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida

City of Malad

CERTIFICATE OF BIRTH

151280

No. _____ St. _____ Registration District No. 26 State File No. _____

Hospital Community Primary Registration District No. 2069 Local Registrar's No. 54

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Apr 10 1927</u> (Month) (Day) (Year)
--------------------------	---	--	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME <u>Dewey Fredrickson</u>	FATHER
RESIDENCE <u>Malad Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Malad, City Ida.</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Olive Hartley</u>	MOTHER
RESIDENCE <u>Malad</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Rockland, Ida.</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

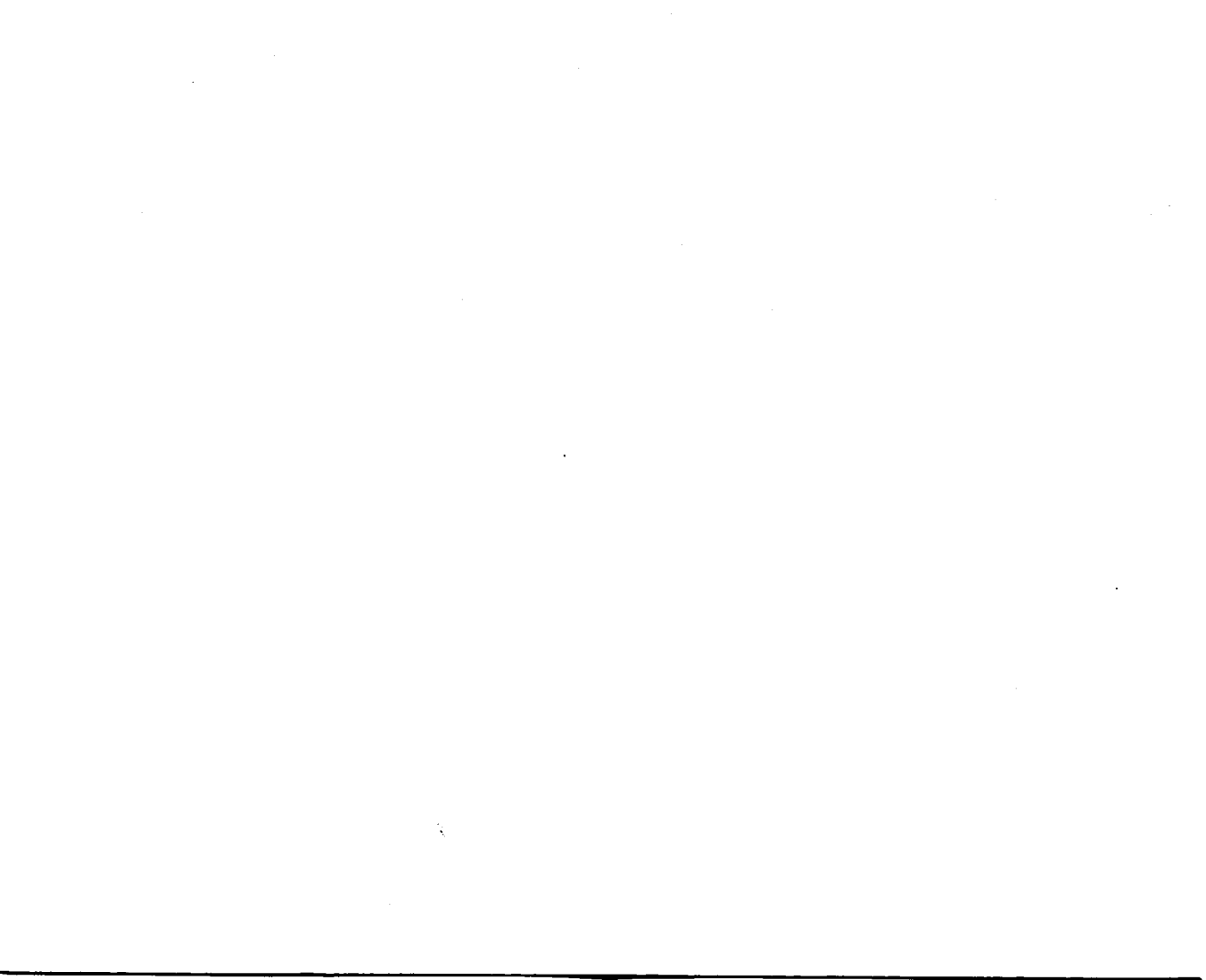
(Signature) [Signature]
M. D.
(Physician or midwife)

Address Malad Idaho

Filed 4/30 1927 J. M. Kern

Registrar.

Registrar.



PLACE OF BIRTH

13 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 151501

County *Pannone*City of *Pawnee*No. *266 21300328*on District No. *88* State File No.Hospital _____ Primary Registration District No. *2160* Local Registrar's No. *289*FULL NAME OF CHILD *No. Maune V Ada Carlson Bowman*

(Certificate of no value without full name of child)

Sex of Child <i>female</i>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <i>yes</i>	Date of birth <i>Apr-13-1927</i>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth *13th* Number of child of this mother now living, including present birth *11*

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<i>George Bowman</i>		<i>Emma Jensen</i>	
RESIDENCE	<i>Pawnee, Idaho</i>	RESIDENCE	<i>Pawnee, Idaho</i>
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>52</i> (Years)	COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>44</i> (Years)
BIRTHPLACE	<i>Richmond, Mich</i>	BIRTHPLACE	<i>Richmond, Mich</i>
OCCUPATION	<i>Farmer</i>	OCCUPATION	<i>Housewife</i>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *born alive* at *2:10* P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

(Physician or midwife)

Address

Filed

May 10 1927

Registrar.

STATE OF TEXAS

DEPARTMENT OF STATE

OFFICE OF THE SECRETARY

OF THE STATE

OF TEXAS

PLACE OF BIRTH



RECEIVED MAY 13 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Bannock

City of

Dawson

Registration District No.

88

Primary Registration District No.

2160

(No.

St.)

File No.

57399

Registered No.

65-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No Name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April - 13 - 1927
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Dawson, Idaho.

10. NAME OF FATHER

George Bowman

11. BIRTHPLACE OF FATHER

(State or Country)

Richmond, Wt.

12. MAIDEN NAME OF MOTHER

Eunna Samson

13. BIRTHPLACE OF MOTHER

(State or Country)

Richmond, Wt.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Bowman

(Address)

Dawson, Idaho

15.

Filed May 10 - 1927

Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy,
8th month gestation.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

(Address)

Dawson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lambert, Idaho

DATE OF BURIAL

4-17-1927

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock." "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

515-117003455
PLACE OF BIRTH

RECEIVED MAY 20 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 51540

County of Barnock
City of Pocatello

No. 12 St. 12
Hospital Pocatello

Registration District No. 28 State File No. 12

FULL NAME OF CHILD

Primary Registration District No. 2161 Local Registrar's No. 8126

John Van Rays

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 4-11 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Albert Raymond Van Rays
RESIDENCE Pocatello Idaho

MOTHER
FULL MAIDEN NAME Ernest Reesor
RESIDENCE same

COLOR wh AGE AT LAST BIRTHDAY 48 (Years)
BIRTHPLACE Indiana
OCCUPATION Professor U.S.S.

COLOR wh AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Michigan
OCCUPATION wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn ✓ at 2: a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. C. Ray

(Physician or midwife)

Address

Pocatello, Idaho

Filed

7/1 1927

Registrar.

Registrar.

1823

47

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAY 20 1927

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57379

County of Bannock
City of Pocatello

Registration District No. 2-667

Primary Registration District No. 2-667

Local Registrar's No. 5032

(No. General Hosp. Pocatello)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Van Nuys

(a) Residence No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

16 DATE OF DEATH April 17 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from 4-17, 1927, to 4-17, 1927, that I last saw him alive on , 19 , and that death occurred, on the date stated above, at m.

6 DATE OF BIRTH (month, day and year) April 17, 27
7 AGE Years Months Days 1 If LESS than day, hrs. or min.

The CAUSE OF DEATH* was as follows:
Kidney and
head several hours
before birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

10 NAME OF FATHER A. R. Van Nuys
11 BIRTHPLACE OF FATHER (city or town) Indiana
(State or country)
12 MAIDEN NAME OF MOTHER Emil L. Peesor
13 BIRTHPLACE OF MOTHER (city or town) Michigan
(State or country)

(Signed) J. B. Ray, M.
April 17, 1927 (Address) Pocatello, Idaho
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 Informant A. R. Van Nuys
(Address) 810 So 8th Pocatello, Idaho

19 Place of Burial, Cremation, or Removal Mountain View Cem. Date of Burial April 17, 1927

15 Filed April 19, 1927 Idaho
Registrar

20. Undertaker H. L. McHan Pocatello, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of _____

CERTIFICATE OF BIRTH

No. 652-226 009-368 St. Registration District No. 78 State File No. 151605

Hospital _____ Primary Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD (unnamed) Webb
(Certificate of no value without full name of child)

Sex of Child female { Twin Twin or other? } and { Number in order of birth 1 } Legitimate? Yes Date of birth April 26, 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 87 Number of child of this mother now living, including present birth 86

FATHER
FULL NAME John A. Webb
RESIDENCE Granite, Idaho
COLOR white AGE AT LAST BIRTHDAY 49
(Years)
BIRTHPLACE Mo.
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Carrie E. Royle
RESIDENCE Granite, Idaho
COLOR white AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE Kans.
OCCUPATION house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 9:25 A. M. on the date above stated.

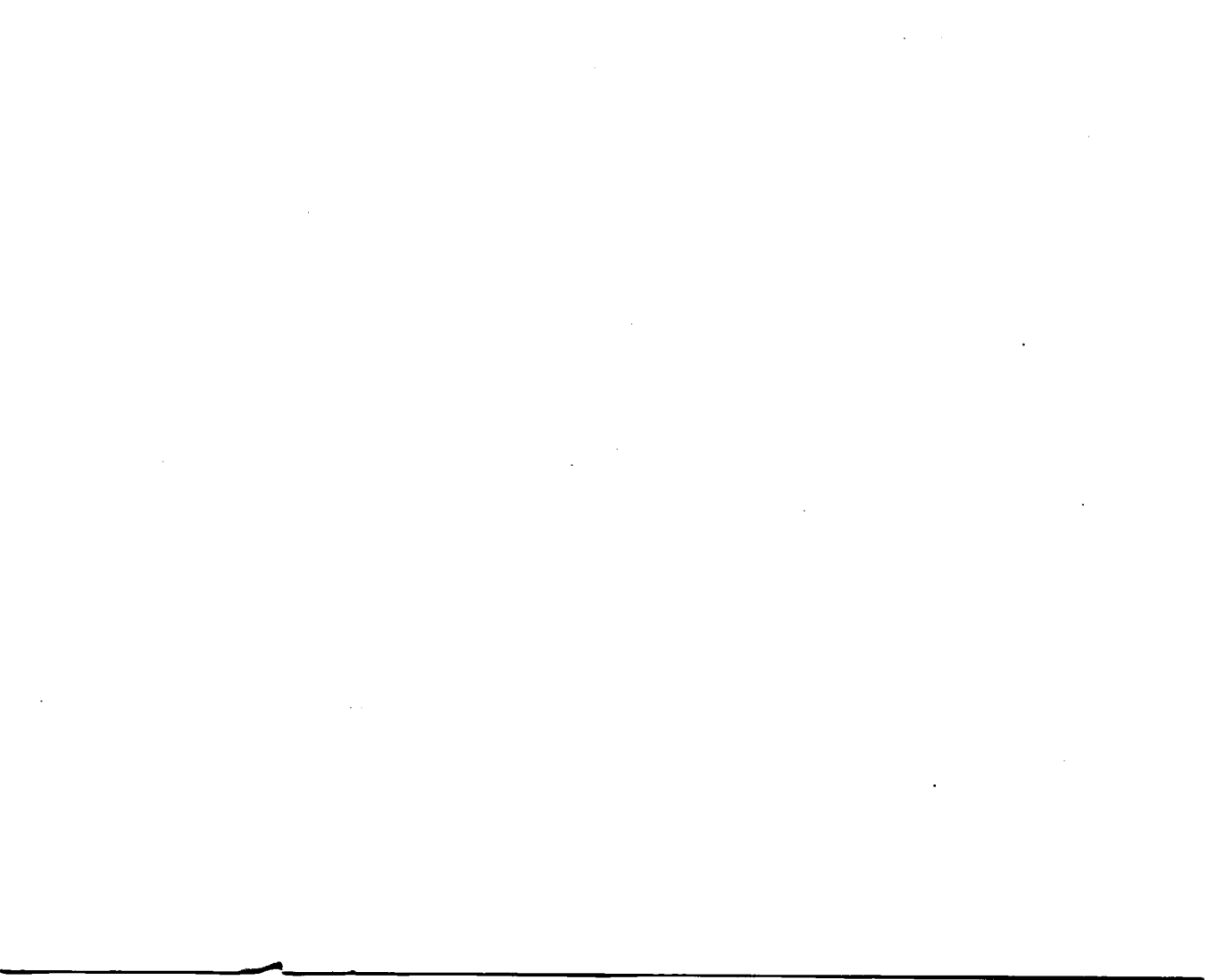
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1927

(Signature) Frank Hanz
Physician
(Physician or midwife)

Address Rathdrum, Idaho

Filed June 3 1927 Viola Allen
Deputy Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

377-205009-291
PLACE OF BIRTH

RECEIVED JUN 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Donner
City of Orderay Sandpoint CERTIFICATE OF BIRTH 151617
No. _____ St. Registration District No. 78 State File No. _____
Hospital Page Primary Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD Betty La Maureaux
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth May 3 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Edw. Pierce La Maureaux</u>	<u>Orderay</u>	<u>Daisy Kramer</u>	<u>Orderay</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)		
BIRTHPLACE <u>Maureport, Iowa</u>	BIRTHPLACE <u>S. Dak.</u>		
OCCUPATION <u>Operator</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Delivered at 7:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

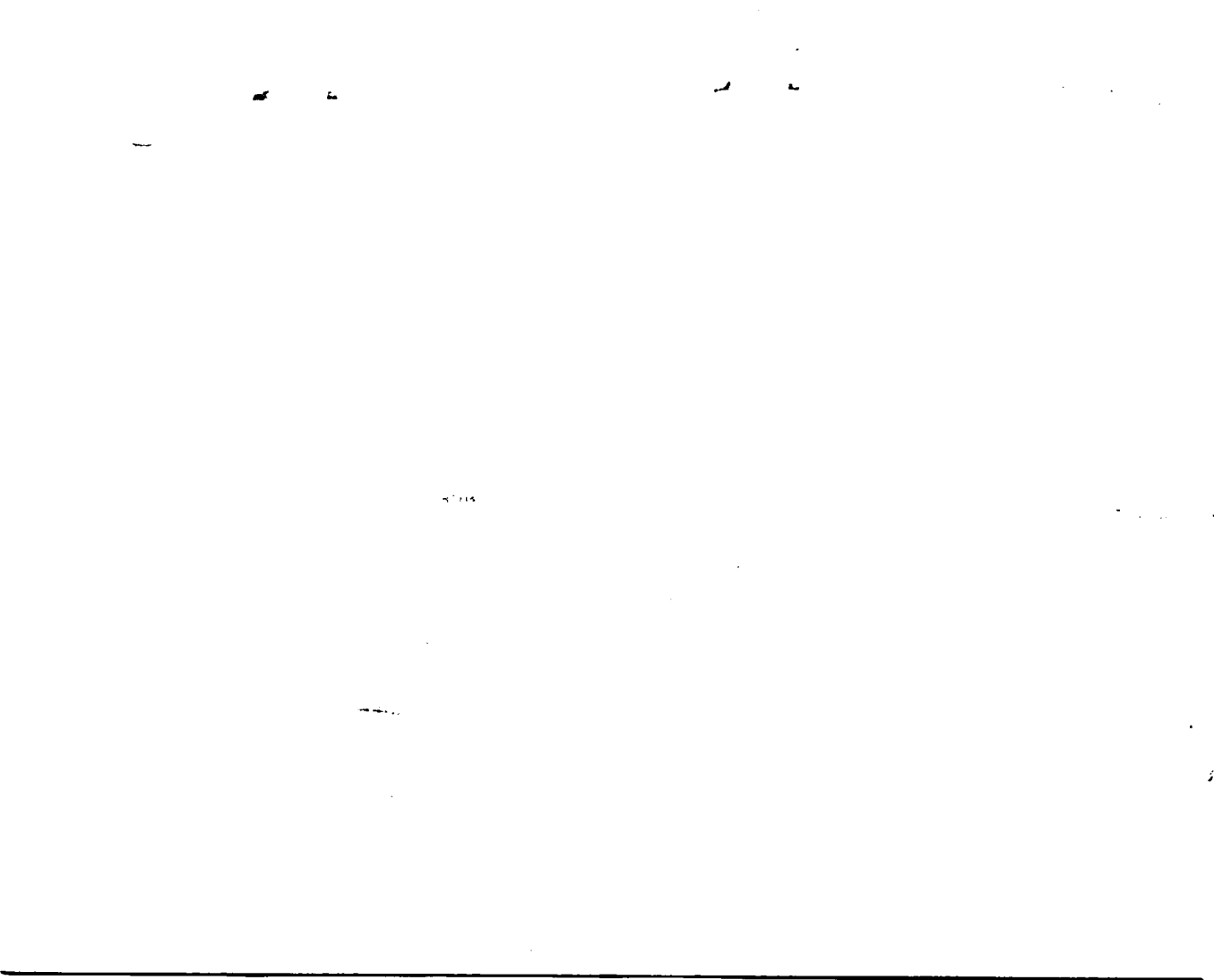
(Signature) A. F. Page M.D.

(Physician or midwife)

Address Sandpoint Ida.

Filed June 3 1927 Viola Allen Deputy Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 57461

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant. La Moreaux

(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER Edward Pierce La Moreaux

11. BIRTHPLACE OF FATHER (city or town) Davenport
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Daisy Cramer

18. BIRTHPLACE OF MOTHER (city or town) Hot Springs
(State or Country) Arkansas

14. Informant E. P. J. La Moreaux
(Address) Tonderay, Idaho

15. Filed May 4, 1927 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Difficult labor.
Florentia previa complete;
Eighth month + one week.
(duration) yrs. mos. ds.

CONTRIBUTORY Florentia previa
(Secondary) Refused cesarian
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of
Was there an autopsy?

What test confirmed diagnosis?
(Signed) E. P. J. La Moreaux, M. D.
May 4, 1927 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Laurel Cemetery Date of Burial May 4, 1927

20. Undertaker L. S. Moon Address Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

466-708-070-466
PLACE OF BIRTH

RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH 151682

No. _____ St. Registration District No. 73 State File No. _____

Hospital L. D. S. Primary Registration District No. 203 Local Registrar's No. 172

FULL NAME OF CHILD Stillbirth

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? 0 and { Number in order of birth 0 Legitimate? no Date of birth 4-8-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME
RESIDENCE
COLOR
AGE AT LAST BIRTHDAY
BIRTHPLACE
OCCUPATION

MOTHER
FULL MAIDEN NAME Ruth Mae Moore
RESIDENCE P. 9 by, Idaho
COLOR white AGE AT LAST BIRTHDAY 17
BIRTHPLACE P. 9 by, Idaho
OCCUPATION Housework

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive 50 Stillborn 10 } P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. R. Hart

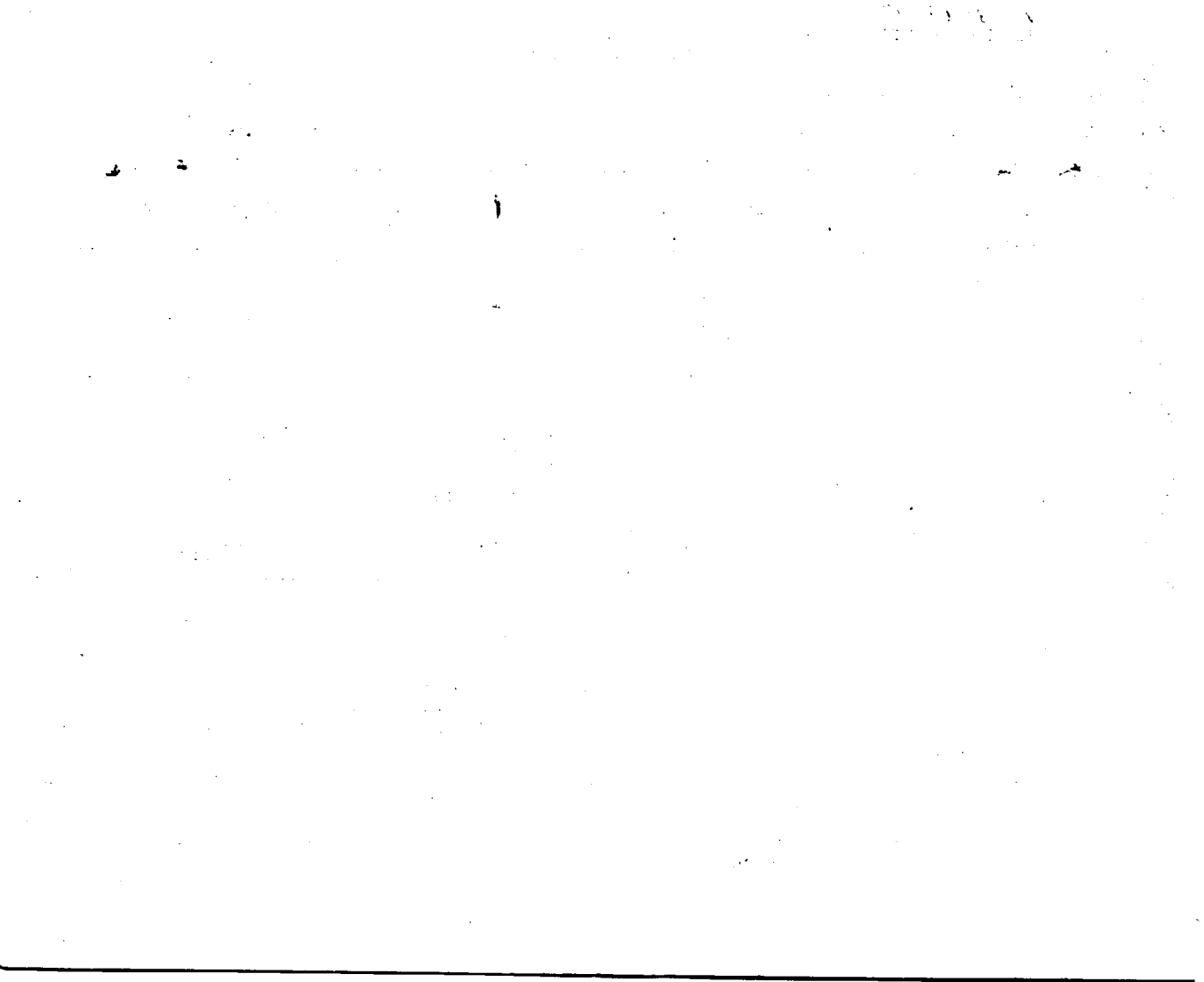
(Physician or midwife)

Address P. 9 by, Idaho

Filed Apr 13 1927 W. H. H. H.

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH *Boomerle* **CERTIFICATE OF DEATH**
County of *Boomerle* **Registration District No.** *73*
City of *Idaho Falls* **Primary Registration District No.** *21*
 If death occurs away from usual residence, give facts called for under special information. **2. FULL NAME** *Stillbirth*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *57496*
Local Registrar's No. *41*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Baby*
 (Write the word)

6. DATE OF BIRTH

4 (Month) *8* (Day) *1* (Year)

7. AGE*Still birth*

IF LESS than 1 day how many
 _____ hrs. or
 _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*L.D.S. Hospital Idaho Falls, Idaho***10. NAME OF FATHER***?***11. BIRTHPLACE OF FATHER**

(State or Country)

*?***12. MAIDEN NAME OF MOTHER***Ruth M Moore***13. BIRTHPLACE OF MOTHER**

(State or Country)

*Rigby, Ida.***14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

Ruth Moore

(Address)

*Rigby, Idaho***15.**

Filed

*Apr 13*19 *27*

Confession
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) *8* (Day) *1927* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 8 1927 to *April 8* 1927,
 that I last saw him alive on *April 8* 1927,

and that death occurred on the date stated above, at *10⁵⁰ P.M.*

The CAUSE OF DEATH* was as follows:

Stillbirth 6 months premature

(Duration) yrs. mos. ds.

Contributory

(Secondary)

Accidental Fall

(Duration) yrs. mos. ds.

(Signed)

M. P. West

M. D.

19.

(Address)

Rigby, Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. *1/2* days In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

*Rigby, Idaho***19. PLACE OF BURIAL OR REMOVAL**

DATE OF BURIAL

*Cremated**Apr 13* 19 *27***20. UNDERTAKER**

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

315-709 010-363
PLACE OF BIRTH

RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bonneville
City of Idaho Falls, Idaho.

CERTIFICATE OF BIRTH

No. 228-Hill St. St. Registration District No. 73 State File No. 151685
Hospital L. D. S. Primary Registration District No. 2/V-2 Local Registrar's No. 146

FULL NAME OF CHILD Stillbirth
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	<u>Twin</u> <u>Triplet</u> -- } and { <u>Number</u> or other? in order (To be answered only in event of plural births)	<u>Legitimate</u> <u>yes</u>	Date of birth <u>April 9,</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	------------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Morris W. Tavenner
RESIDENCE Idaho Falls, Idaho. 228-Hill
COLOR white AGE AT LAST BIRTHDAY 34
(Years)
BIRTHPLACE Ohio
OCCUPATION Pipe fitter

MOTHER
FULL MAIDEN NAME Leah Colson
RESIDENCE Idaho Falls, 228 Hill St.
COLOR white AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 11:18 A.M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address Idaho Falls, Idaho.

Filed Apr 14 1927 Registrar.

RECEIVED BY THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF THE INTERIOR, WASHINGTON, D. C. JAN 11 1918

Give names added from a supplementary report.
 shows after extinction of life after birth.
 child is one that neither breathes nor
 etc. should make this return. A stillborn
 or killed then the father, householder
 or person there was an attending physician
 of the date above stated.

I hereby certify that I attended the birth of the child, who was Stillborn 1:18 A.M.
 on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.
 Occupation Physician
 Birthplace Ohio
 Color White
 Age at last birthday 38

RESIDENCE Idaho Falls, Idaho.
 NAME Mortimer W. Stevenson
 FATHER Idaho Falls, Idaho.
 Mother of child, the mother, including present birth 1
 What local hospital station was used in event

CHILD NAME OF CHILD Settled
 (Indication of no child without last name of child)
 Sex of child Male
 Date of birth Jan 11 1918
 Time of birth 1:18
 Place of birth Idaho Falls, Idaho
 (Year) 1918

County of Bonneville
 State of Idaho
 228-111-34
 P. D. 3.
 Primary Registration District No. 1
 Registration District No. 1
 State of Idaho

Address Idaho Falls, Idaho
 (Indication of midwife)
 Registrar

Occupation Physician
 Birthplace Idaho
 Color White
 Age at last birthday 38

RESIDENCE Idaho Falls, Idaho.
 NAME Mortimer W. Stevenson
 FATHER Idaho Falls, Idaho.
 Mother of child, the mother, including present birth 1
 What local hospital station was used in event

CHILD NAME OF CHILD Settled
 (Indication of no child without last name of child)
 Sex of child Male
 Date of birth Jan 11 1918
 Time of birth 1:18
 Place of birth Idaho Falls, Idaho
 (Year) 1918

County of Bonneville
 State of Idaho
 228-111-34
 P. D. 3.
 Primary Registration District No. 1
 Registration District No. 1
 State of Idaho

County of Bonneville
 State of Idaho
 228-111-34
 P. D. 3.
 Primary Registration District No. 1
 Registration District No. 1
 State of Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train**—**accident**; **Revolver wound of head**—**homicide**; **Poisoned by carbolic acid**—**probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS
N. B.—In case of more than one child at birth a SEPARATE
entry must be made for each and the number of each, in order of

692-101010-343
AGE OF BIRTH Bornville
Idaho Falls
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 151701
St. Registration District No. 73 State File No. 124
Primary Registration District No. 2145 Local Registrar's No. 124
NAME OF CHILD Stefan, William Orson
(Certificate of no value without full name of child)

Male Male Twin Triplet or other? and { Number in order of birth } Legiti- mate? yes Date of birth 4-1 192 7
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>3</u>	
FATHER		MOTHER	
FULL NAME <u>James Stagner</u>		FULL MAIDEN NAME <u>Edna May Culbins</u>	
RESIDENCE <u>Idaho Falls</u>		RESIDENCE <u>Idaho Falls</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Colorado</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } 30 at 9:30 P. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Stefan

(Physician or midwife)

Address Apr 4 1927 Idaho Falls

Filed Apr 4 1927

Registrar.

RESEARCH DESIGN

16-25

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED MAY 14 1927
PLACE OF DEATH
COUNTY OF Bonneville
CITY OF Idaho Falls
REGISTRATION DISTRICT NO. 23
PRIMARY REGISTRATION DISTRICT NO. 21170

DO NOT WRITE IN THIS SPACE

State File No. 57489

Local Registrar's No. 34

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William O. Stagner

(a) Residence. No. 330-7th St. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of no.
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 1, 1877

7 AGE Years Months Days 0 0 0
1 day, 0 hrs. or 0 min. If LESS than

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10 NAME OF FATHER James Stagner

11 BIRTHPLACE OF FATHER (city or town) Salida Colo.
(State or country)

12 MAIDEN NAME OF MOTHER Edna May Calhoun

13 BIRTHPLACE OF MOTHER (city or town) Ammon Idaho
(State or country)

14 Informant James Stagner
(Address) 370-7th Idaho Falls

15 Apr 2, 19 27 William O. Stagner
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 1 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 27, to April 1, 19 27, that I last saw him alive on St. Bon. and that death occurred, on the date stated above, at 22 m.

THE CAUSE OF DEATH* was as follows:

Prolapsus Cord.

(duration) yrs. mos. ds.
CONTRIBUTORY Same
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓
if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? obstetric Ex.

(Signed) H. D. Smith M. D.
April 2, 19 27 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial April 27

20. Undertaker T. F. McHew Address Idaho Falls, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic Interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of BonanzaCity of Bonners Ferry

CERTIFICATE OF BIRTH

151706

No. 253-111-011-431St. Registration District No. 79State File No. 3156

Hospital

Primary Registration District No. 3156

Local Registrar's No.

FULL NAME OF CHILD

Anthony Bellings

(Certificate of no value without full name of child)

Sex of Child

maleTwin
Triplet
or other?

}

and {

Number
in order
of birth3Legiti-
mate?yesDate of
birthApr. 11 1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

5

Number of child of this mother now living, including present birth

4FULL
NAME

FATHER

Arthur Couras Bellings

RESIDENCE

Bonners Ferry

COLOR

whiteAGE AT LAST
BIRTHDAY40

(Years)

BIRTHPLACE

New York

OCCUPATION

U.S. - Border PatrolFULL
MAIDEN
NAME

MOTHER

Anna McAluse

RESIDENCE

Bonners Ferry

COLOR

whiteAGE AT LAST
BIRTHDAY30

(Years)

BIRTHPLACE

B.C.

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn Dead alive at 3.20 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

S.E. Fry
Physician

(Physician or midwife)

Address

Bonners Ferry, Ida.

Filed

Apr. 14 1927

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

DEPARTMENT OF PUBLIC HEALTH
 DIVISION OF VITAL RECORDS
 BIRTH CERTIFICATE OF MARY ANN
 BORN MAY 10, 1924
 AT NEW YORK CITY
 NEW YORK

4408

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
 DIVISION OF VITAL RECORDS
 BIRTH CERTIFICATE OF MARY ANN

County of NEW YORK
 City of NEW YORK
 Birth Date MAY 10 1924
 Birth Time 11:00 AM
 Primary Registration District No. 12
 Local Registration District No. 12

FULL NAME OF CHILD
 (Child to be named within ten days of birth)
 Sex of Child Female
 Date of Birth MAY 10 1924
 Time of Birth 11:00 AM
 Place of Birth NEW YORK CITY
 (To be completed only in event of special birth)

What information sources were used in event of special birth?

Number of child of this mother, including present birth
 Number of child of this mother, including present birth

FATHER
 FULL NAME
 RESIDENCE
 MOTHER
 FULL NAME
 RESIDENCE

COLOR
 AGE AT LAST BIRTHDAY
 COLOR
 AGE AT LAST BIRTHDAY

BIRTHPLACE

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive }
 at NEW YORK CITY

(Signature)
 (Physician or midwife)
 Address

Filed at NEW YORK on MAY 10 1924

Give names of all persons attending the birth of this child.
 When there was no attending physician or midwife, then the father, mother, or other person present at the birth, should make this report. A child is one that has never been born before. It is one that has never been born before. It is one that has never been born before.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

RECEIVED MAY 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 57507

Local Registrar's No.

Local Registrar's Name

FORM V. S. No. 5-20-1-1-25

CERTIFICATE OF DEATH

Registration District No. 29

Primary Registration District No. 2154

(No.) (St.)

Local Registrar's Name

1. PLACE OF DEATH

County of Boundary

City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anthony Belling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

9. BIRTHPLACE

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

15. FILED

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

(Address)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

DATE OF BURIAL

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED JUN 13 1927

PLACE OF BIRTH

STATE OF IDAHO

County of Canyon
City of Caldwell, Ida
No. Cald. Sanitarium St.
869121014763

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 3 State File No. 151774
Prim. Registration District No. 1005 Local Registrar's No. 60

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u>1st</u>	Legitimate? <u>yes</u>	Date of birth <u>May 21</u> 19 <u>27</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? X

Number of child of this mother, including present birth 1st (a) Born alive and now living

Born alive but now dead Stillborn yes

FATHER FULL NAME <u>Jordon F. Harlock</u>	MOTHER FULL MAIDEN NAME <u>Winifred Polackson</u>
--	--

Residence (Usual place of abode) Behrman Apts 11th St

If nonresident, give place and State

Color or race white Age at last Birthday 27 (Years)

Birthplace Missouri (City and State or Country)

Occupation Foreman - Smelter

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at on the date above stated.

(Signature) S. B. Dudley

(Physician or midwife)

Address Caldwell, Ida

Filed 5-25- 1927 John S. Meyer Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 3 State File No. 15113
 Birth Registration District No. 10 Local Registration No. 10

CHILD'S NAME OF CHILD

(If different, substitute the word "CHILD" in place of "NAME")
 Sex of Child Male Date of Birth 1913
 Month 12 Day 25 Year 1913
 To be answered only in case of stillbirth

What prophylactic was used to prevent (Syphilitic) Neosporism?

Name of child at the mother, including previous birth John
 Born alive or stillborn born alive

FATHER

Name John (Last, first and middle)
 Residence (Last, first and middle) 111
 City and State or County 111

Place of birth 111 (Last, first and middle)
 City and State or County 111

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born
 on the date above stated.

(Signature)

Address 111
 City 111 State 111
 I have made no statement in relation to this child, nor should I make the same. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

PROVIDED THAT THE CHILD IS NOT A STILLBORN CHILD AND THAT THE CHILD IS NOT A STILLBORN CHILD AND THAT THE CHILD IS NOT A STILLBORN CHILD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **57542**

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1003

Local Registrar's No. 55

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Horlock
(a) Residence. No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>—</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>—</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>—</u>		
6. DATE OF BIRTH (month, day and year) <u>May 21-27</u>		
7. AGE Years <u>—</u>	Months <u>—</u>	Days <u>—</u> If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> (c) Name of employer <u>—</u>		

9. BIRTHPLACE (city or town) (State or country) <u>Caldwell</u> <u>Idaho</u>	10. NAME OF FATHER <u>Gordon F. Horlock</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Missouri</u>	12. MAIDEN NAME OF MOTHER <u>Winifred Blackston</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>	14. Informant <u>Gordon F. Horlock</u> (Address) <u>Caldwell Ida</u>
15. Filed <u>5-24-1927</u>	<u>John S. Meyer</u> Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1927, to May 21, 1927
that I last saw him alive on that date, 1927
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
accidental
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis?
(Signed) S. S. S. S. M. D.
, 1927 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Canyon Hill</u>	Date of Burial <u>May 24</u> 19 <u>27</u>
20. Undertaker <u>C. D. Beckham</u>	Address <u>Caldwell Ida</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

Registrar

ALL INFORMATION CONTAINED

It is a known fact that the word "and" is used to connect two or more things.

257 258

...the original was used to prevent (phthalate) contamination.

...including present and

~~CONFIDENTIAL~~

SECRET

100-441107
MAY 1964
947-1

(-84- to make sure) - 10/10/10

100-443887-1

et al.

39248

(City and State or Country)

90512

~~CONFIDENTIAL~~

SECRET - (S)

STATE OF TEXAS, COUNTY OF DALLAS.

(1970 0108)

50

From these words I
learned that the

(STANDARD)

(S) (U)

0-3301 1107310

529th

1997

shows other evidence of the fact that neither brother nor sister is one that would be likely to leave a note in the room. A note should have been left by the father, for example, if he had been there. There was no clothing hanging in the room, and the father, for example, would have been likely to leave a note in the room. The father, for example, would have been likely to leave a note in the room. The father, for example, would have been likely to leave a note in the room.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PLACE OF DEATH

County of Canyon
City of Caldwell

RECEIVED JUN 1 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 57518

Local Registrar's No. 50

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Mitchell

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE _____ 5. Single, Married, Widowed, or Divorced (write the word) _____

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of L. A. Mitchell

6. DATE OF BIRTH (month, day and year)

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Idaho
(State or country)

10. NAME OF FATHER L. A. Mitchell

11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Agnes Irene Rose

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant L. A. Mitchell
(Address) Caldwell R#3 Ida

15. Filed 5-12- 1927 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1927, to May 11 1927
that I last saw her alive on May 11 1927
and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH was as follows:

Still birth.

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Memorial-Freedom
(Second) Birth Record Marginalia
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. Dudley M. D.
5-12-1927 (Address) Caldwell
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pleasant Ridge Date of Burial 5-12 1927

20. Undertaker C. V. Dickham Address Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

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DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

391110 014 2693

PLACE OF BIRTH

RECEIVED

JUN 13 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Canyon

City of Notus

No. _____ St.

Caldwell Sanitarium

(If born in hospital or institution
give name.)

Registration District No. 3 State File No. 151783

Prim. Registration District No. 2005 Local Registrar's No. 51

FULL NAME OF CHILD Stillberth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	<u>Male</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5/10</u>	<u>1927</u>
		(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER FULL NAME <u>Chas. L. Crawford</u>	MOTHER FULL MAIDEN NAME <u>Laura Wilson</u>
--	--

Residence (Usual place of abode) Notus, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 44 (Years)

Birthplace Missouri (City and State or Country)

Occupation Farming

Color or race White Age at last Birthday 36 (Years)

Birthplace Georgia (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:30 A. M.
on the date above stated.

(Signature) S. B. Dudley

M. D.

(Physician or midwife)

Address Caldwell, Idaho

Filed 5-12- 1927 John B. Meyer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 11
Prior Registration District No. 11
State File No. 11

The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

The child was born to the following parents:

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<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

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The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

The child was born to the following parents:

Child's Name	Child's Sex	Child's Race	Child's Date of Birth	Child's Place of Birth
<u>Charles I. Crawford</u>	<u>Male</u>	<u>White</u>	<u>April 11, 1911</u>	<u>Chicago, Illinois</u>

There were no attending physician
attending the child at birth. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Chicago, Illinois
Signed Charles I. Crawford
(Signature)
Date April 11, 1911
(Date of Birth)

I hereby certify that I attended the birth of this child, who was born on the date above stated.

(Signature)
Date

(Signature of mother)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. 861-103016154

Registration District No. 117

State File No. 151791

Hospital

Primary Registration District No. 2196

Local Registrar's No. 3611

FULL NAME OF CHILD

* Still Born

(Certificate of no value without full name of child)

Sex of
Child

011

Twin
Triplet
or other?

— }

and {

Number
in order
of birth

— }

Legiti-
mate?

Date of
birth

April 9

1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

20% silver

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

E. G. Haug

RESIDENCE

Burley

COLOR

white

AGE AT LAST
BIRTHDAY

27
(Years)

BIRTHPLACE

Warm Creek Idaho

OCCUPATION

Labourer

FULL
MAIDEN
NAME

MOTHER

Leone Anderson

RESIDENCE

Burley

COLOR

white

AGE AT LAST
BIRTHDAY

22
(Years)

BIRTHPLACE

Sandeville Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn 10 A M
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

W. A. Albee

(Physician or midwife)

Address

Burley Ida.

Filed 5-1-27 192

R. J. Patterson

Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instruction on back of certificate.

RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57572

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196

Local Registrar's No. 904

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 11 Alma St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write this word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) April 9 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9. BIRTHPLACE (city or town) Burley
(State or country)10. NAME OF FATHER E. G. Haag11. BIRTHPLACE OF FATHER (city or town) Warm Creek Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Leone Anderson13. BIRTHPLACE OF MOTHER (city or town) Sanderville W.
(State or Country)

14. Informant E. G. Haag
(Address) Burley Idaho

15. Filed 4-10-27, 19 27
P. J. C. Patterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 9, 1927, to April 9, 1927
that I last saw him live on April 9, 1927
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Still Bored(duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) ✓(duration) 1 yrs. 0 mos. 0 ds.18. Where was disease contracted ✓
if not at place of death?Did an operation precede death? ✓ Date of ✓Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) M. A. Olsen, M. D.4-10, 1927 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Idaho Date of Burial 4-9 1927

20. Undertaker Am Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman," "Manager," "Dealer," etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia**," "**Anaemia**" (merely symptomatic), "**Atrophy**," "**Collapse**," "**Coma**," "**Convulsions**," "**Debility**," ("**Congenital**," "**Senile**," etc.), "**Dropsy**," "**Exhaustion**," "**Heart Failure**," "**Hemorrhage**," "**Inanition**," "**Marasmus**," "**Old age**," "**Shock**," "**Uraemia**," "**Weakness**," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory**."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED MAY 14 1927

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of CassiaCity of Burley, Ida.

CERTIFICATE OF BIRTH

No. 215-213016-1314 St. Registration District No. 117 State File No. 151793Hospital _____ Primary Registration District No. 2196 Local Registrar's No. 3613FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>April 13 1927</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? argyrol sol.Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER		MOTHER	
FULL NAME <u>Napoleon Bankhead</u>	FULL MAIDEN NAME <u>Hanna James</u>		
RESIDENCE <u>Burley, Ida.</u>	RESIDENCE <u>Burley, Ida.</u>		
COLOR <u>White</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Paradise Utah</u>	BIRTHPLACE <u>Paradise Utah</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. H. Cooper M.D.
Physician and Surgeon
(Physician or midwife)

Address Burley, Ida.Filed 5-1-27 N. J. C. Patterson

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THE B. - In case of some such case, it is to be noted that the
 while the other side of the road is to be noted that the
 the other side of the road is to be noted that the
 the other side of the road is to be noted that the

SECRET

381

* When there was no attending physician or nurse, then the father, household etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

on the date above stated.

I hereby certify that I attended the birth of this child, who was born at [redacted] on [redacted]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

DECLASSIFICATION

EDWARD (B)

120

OCULTISMO

BIRTHPLACE

color

三、

1000
1000
1000

REMITA

MAKES FULL

Number of children of this mother, including present birth

It was found that the following persons were living at the time of the murder:

What potential for
Intelligence was
any new born in 1972?

(To be answered only in case of plural parties)

advertising

1. **Wages**
 2. **Hours**

11/29/19

to night

100

...TO ...

Radio Free

Primarily Registration District No. 2

ON 8-18-1964

38

Registration District No. 11

Boat #16 No.

REPUBLIC OF CHINA

ON ARI TO CHINA

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 14 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57568

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. _____)

Local Registrar's No. 900

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Bankhead

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) April 13, 1927

7 AGE Still Born Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Burley Ida.
(State or country)

10 NAME OF FATHER Napoleon Bankhead

11 BIRTHPLACE OF FATHER (city or town) Paradise Wt.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Tams.

13 BIRTHPLACE OF MOTHER (city or town) Paradise Utah.
(State or country)

14 Informant M. Bankhead
(Address) Burley Ida.

15 Filed 4-14-27, 19 Dr. J. C. Patterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 13 1927, to April 13 1927, that last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. H. Cooper M. D.

April 13 1927 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Burley Ida. Date of Burial April 13 1927

20. Undertaker D. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

City of Challis

No. 865-10909962 St. Registration District No. 108 State File No. 151831

Hospital _____ Primary Registration District No. 2186 Local Registrar's No. 125

FULL NAME OF CHILD Jack Clarence Hovey

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>April 9</u> 192 <u>7</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER

FULL NAME Harold N. Hovey

RESIDENCE Idaho

COLOR White AGE AT LAST BIRTHDAY 30 (Years)

BIRTHPLACE Henderson New York

OCCUPATION Bank Cashier

MOTHER

FULL MAIDEN NAME Marquerite Rose Kelly

RESIDENCE Challis Idaho

COLOR White AGE AT LAST BIRTHDAY 27 (Years)

BIRTHPLACE Smithfield Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 4 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) C. L. Kitter

(Physician or midwife)

Address Challis Idaho

Filed April 30 1927 Sam M. Kennedy

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-12

RECEIVED MAY 1 1927 CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Custer
City of Challis
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108
Primary Registration District No. 2186
(No. _____ St.)

State File No. 57587
Local Registrar's No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Clarence Hovey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH April 9 1927
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Challis, Idaho

10. NAME OF FATHER Harold H. Hovey

11. BIRTHPLACE OF FATHER (State or Country) Henderson, N. Y.

12. MAIDEN NAME OF MOTHER Marguerite Roskelley

13. BIRTHPLACE OF MOTHER (State or Country) Smithfield Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harold H. Hovey
(Address) Challis, Ida.

15. Filed April 30 1927 Glenn M. Kenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1927 to April 9 1927, that I last saw him alive on 19, and that death occurred on the date stated above, at 7 P. M. The CAUSE OF DEATH* was as follows:

High forebrain gaske
Drying of head
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. B. Ritchey M. D.
April 30 1927 (Address) Challis, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Challis Idaho DATE OF BURIAL April 11 1927

20. UNDERTAKER Friends ADDRESS Challis, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Fremont

City of Welford

No. 299-23022-249

St. Registration District No. 99

State File No. 151885

Hospital

Primary Registration District No. 2177 Local Registrar's No. 661

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

1 } and {

Number
in order
of birth

5

Legiti-
mate?

yes

Date of
birth

5

13

1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? C

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Melvin Birch

RESIDENCE

Welford Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

39
(Years)

BIRTHPLACE

Welford Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Rosa Bell Smith

RESIDENCE

Welford Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Welford Idaho

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2 h M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

P. M. Kelley

(Physician or midwife)

Address

St Anthony, Idaho

Filed

6/8

1927

Corn Hanson

Registrar.

Registrar.

[illegible]

10 KILLED

10-20-68
1,115

NEW I
INLET
TRAFFIC NO

of Division

(continued from page 10)

10-11-68

... ..
... ..
... ..

(7, 20)

(Continuation of no value without full name of child)

SECRET

1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

Boatwright, Thelma

Abstract

(HITLER'S OWN WORDS)

DEPARTMENT OF AGRICULTURE
BUREAU OF AGRICULTURAL MECHANICS

UNITED STATES

1. Preparation of the solution

Number of calls in this month: _____

100

RENTAL

1104
MAY 1954

ЯЗЫКОМ

REDAIDING

100-443887-100

COLORED

ALTA 30A

1997

(8762)

[illegible]

15-A 1981(75)11

I hereby certify that I attended the birth

There were no attending physician

(b)(7)(D), (b)(7)(F)

follow-up in 1980-1981

2897 DA

best

References

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57970

Local Registrar's No. *205*

PLACE OF DEATH

County of *Fremont*
City of *Wilford*

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME *Premature Infant*

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *girl* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Infant*

5a If married, widowed, or divorced
HUSBAND of *Infant*
(or) WIFE of

6 DATE OF BIRTH (month, day and year) *May 13th 1927*

7 AGE Years Months Days *Premature* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Infant*

(b) General nature of industry, business, or establishment in which employed (or employer) *none*

(c) Name of employer *none*

9 BIRTHPLACE (city or town) *Wilford, Idaho*
(State or country)

10 NAME OF FATHER *Melvin Birch*

11 BIRTHPLACE OF FATHER (city or town) *Wilford, Ida.*
(State or country)

12 MAIDEN NAME OF MOTHER *Rosa B. Smith*

13 BIRTHPLACE OF MOTHER (city or town) *Wilford, Ida.*
(State or country)

14 Informant *Rosa B. Birch*
(Address) *Wilford, Idaho.*

15 Filed *7/2*, 19 *27* *W. W. Hansen*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 13* 19 *27*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 13* 19 *27* to *May 13* 19 *27*
that I last saw her alive on *May 13* 19 *27*
and that death occurred, on the date stated above, at *2 P.* m.

The CAUSE OF DEATH* was as follows:
Premature Birth - Construction of cord.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *✓*
If not at place of death?

Did an operation precede death? *✓* Date of *✓*

Was there an autopsy? *no*

What test confirmed diagnosis? *Constructed cord*

(Signed) *P. M. Kelly*, M. D.

May 13, 19 *27* (Address) *St. Anthony, Ida.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal *Wilford* Date of Burial *May 14* 19 *27*

20. Undertaker *none* Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH **RECEIVED JUN**STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF VITAL STATISTICS

S

County of Gooding

City of _____

No. 281-125024-669 St.

Registration _____

CERTIFICATE OF BIRTH

File No. 151917

Hospital _____

Primary Registration District No. _____

Registered No. 179FULL NAME OF CHILD Baby Shaw

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5 25</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? noneNumber of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1FULL NAME FATHER
Harold A ShawFULL MAIDEN NAME MOTHER
Thelma FardickRESIDENCE GoodingRESIDENCE GoodingCOLOR white AGE AT LAST BIRTHDAY 26
(Years)COLOR white AGE AT LAST BIRTHDAY 22
(Years)BIRTHPLACE UtahBIRTHPLACE KansasOCCUPATION FarmerOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 4:36 9 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Houston E. Fryder

(Physician or midwife)

Give names added from a supplemental report.

5-31- 1927
J. Hermonway
 Registrar.

Address _____

Filed 5-28 1927 J. Hermonway
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



RECEIVED JUN 4 1927 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24

County of

Primary Registration District No.

File No. 57624

City of

(No. St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single

(Write the word.)

6. DATE OF BIRTH

5 25 1927
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harold A. Shaw

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Thelma E. Fardice

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold Shaw

(Address)

Gooding Idaho

15.

Filed

5731

1927

J. H. Cromwell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 25 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-25 1927, to 5-25 1927

that I last saw him alive on Stillborn 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia
operative delivery

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Hoerston E. Snyder M. D.

5-26 1927 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding Idaho

DATE OF BURIAL

5-25 1927

20. UNDERTAKER

A. E. Thompson

ADDRESS

Gooding Idaho

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STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 4 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Gooding

City of "

CERTIFICATE OF BIRTH 151920

No 552.125.024265

Registration District No. 24

State File No. 151920

Hospital "

Primary Registration District No. "

Local Registrar's No. 171

FULL NAME OF CHILD

Marique Ennesma

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate

yes

Date of
birth

May 25 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 5

FULL
NAME

FATHER

Gregoria Ennesma

RESIDENCE

Gooding Idaho

COLOR

white

AGE AT LAST

BIRTHDAY 38
(Years)

BIRTHPLACE

Spain

OCCUPATION

Farming

FULL
MAIDEN
NAME

MOTHER

Imota Sinegar

RESIDENCE

Gooding Idaho

COLOR

white

AGE AT LAST

BIRTHDAY 35
(Years)

BIRTHPLACE

Spain

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

192

Registrar.

(Signature)

J H Cromwell

(Physician or midwife)

Address

Gooding Idaho

Filed 5/28 1927

Registrar.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATIONS
155 WEST 42ND STREET
NEW YORK 36, N. Y.

...the ...
...the ...
...the ...
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CERTIFICATE OF ATTENDING PHYSICIAN OR NURSE

I would certify that I attended the birth of this child who was delivered on

DECLASSIFICATION

DATE

ADJUD

MEMORANDUM

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RIGHT

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NOTATION

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(Classification of material)

(S-0148812)

207126-9

PLACE OF DEATH

RECEIVED JUN 4 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsCounty of GroshenRegistration District No. 24File No. 57620City of Idaho

(No. _____ St.)

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gregoria Escurusa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Boy 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

5 - 25 - 27
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Gording - Ida

10. NAME OF FATHER

Gregoria Escurusa

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Timota Suega

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claudio Esquina
Gording Ida

(Address)

15.

Filed

5 - 26 - 1927 J H Cromwell
Local Registrar

16. DATE OF DEATH

5 - 25 - 27
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. 19 alive on 19and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Stillborn - gestation fuel
cause unknown(Duration) Yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.

(Signed)

J H Cromwell

M. D.

5-26-1927 (Address) Gording Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gording Ida

DATE OF BURIAL

5-26-1927

20. UNDERTAKER

A E Thompson

ADDRESS

Gording

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 12 1927

STATE MAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Roberts Star route

CERTIFICATE OF BIRTH 151979

No. 339124026-235 St. Registration District No. 98 State File No. 151979

Hospital _____ Primary Registration District No. 276 Local Registrar's No. 86

FULL NAME OF CHILD Sullivan

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>3/24</u> 192 <u>7</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7

FULL NAME FATHER Ormy C Clifford

FULL MAIDEN NAME MOTHER Grace Stephens

RESIDENCE Roberts Star route

RESIDENCE Same

COLOR W AGE AT LAST BIRTHDAY 39 (Years)

COLOR W AGE AT LAST BIRTHDAY 39 (Years)

BIRTHPLACE Wash

BIRTHPLACE Ila

OCCUPATION Farmer

OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Earl Jones

(Physician or midwife)

Give names added from a supplemental report.

Address Roberts Star route

Filed MAY 1 1927

Registrar.

Registrar.

WITH NO REVENUE

SECRET

05-198700-2000

Patent 2,164,774

100-100-11

PLEASE PRINT NAME OF ORIGINATOR

Instead of no time without the name of Christ

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1997-1998

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To be answered only in event of change of address

ENTERED BY MAIL NEW POSTAGE LABELS AND JUNE 1971

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REPORT

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OCCLUSION

מדינת ישראל

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

in 1961, I was only 11 years old and I had not yet reached the age of 18.

State, under such conditions.

[illegible]

SN

707324

RECEIVED MAY 12 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/24 1927 to 3/24 1927

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Sudden probably due to
multiparous maternal hemorrhages

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Jones M. D.

19 (Address) Roberts Ida for nurse

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

RECEIVED JUN 9 1927
PLACE OF BIRTH
395 120 027 367

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Blaine

City of Blaine

No. _____ St. _____

Registration District No. 23

File No. 152061

Hospital _____

Primary Registration District No. 2017

Registered No. 52

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>1</u> and <u>1</u> Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of birth <u>Jan 20</u> 192 <u>7</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bactericidal solution was used in eyes? D.P. Glycerol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Epifanio Dominguez
RESIDENCE Blaine, Ida.
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Ill.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Lucia
RESIDENCE Blaine, Ida.
COLOR White AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Arkansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Blaine 4:30 P.M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. C. F. Zeller
Dr. H. C. Zeller
(Physician or midwife)

Give names added from a supplemental report.

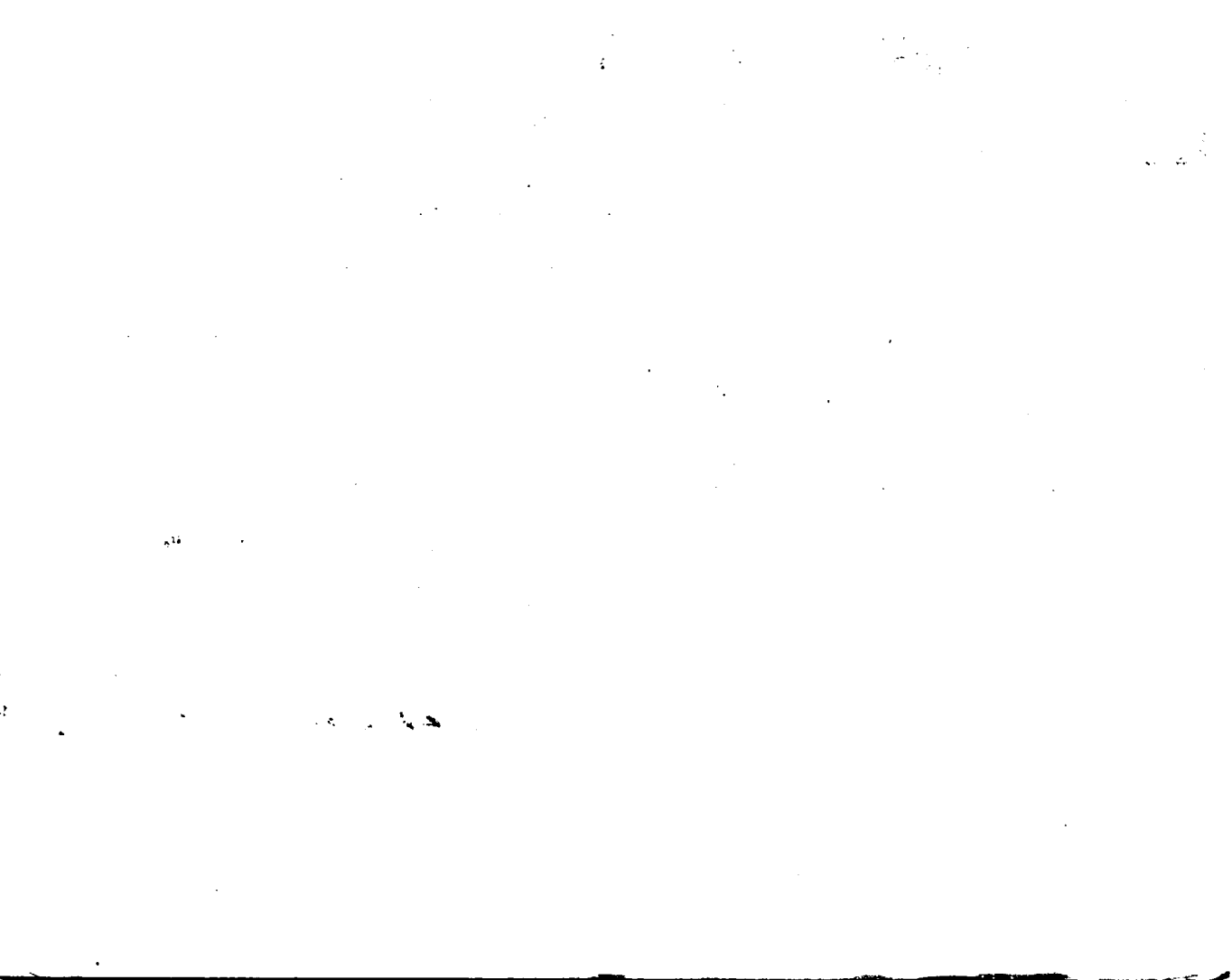
_____, 19____

Address _____

Filed 6-3 1927 E. H. Bunn

Registrar.

Registrar.



PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of KootenaiCity of Rathdrum

CERTIFICATE OF BIRTH

No. 99-12508-286 St. Registration District No. 30 State File No. 152085Hospital _____ Primary Registration District No. 1051 Local Registrar's No. _____FULL NAME OF CHILD unnamed Kirchknopf
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>April 25, 1927</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME John E. Kirchknopf
RESIDENCE Rathdrum, Ida. R. 2
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Idaho
OCCUPATION woodsman

MOTHER
FULL MAIDEN NAME Mary L. Shove
RESIDENCE Rathdrum, Ida. R. 2
COLOR white AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Pa.
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7.12. P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Frank Henry
Physician
(Physician or midwife)

Address

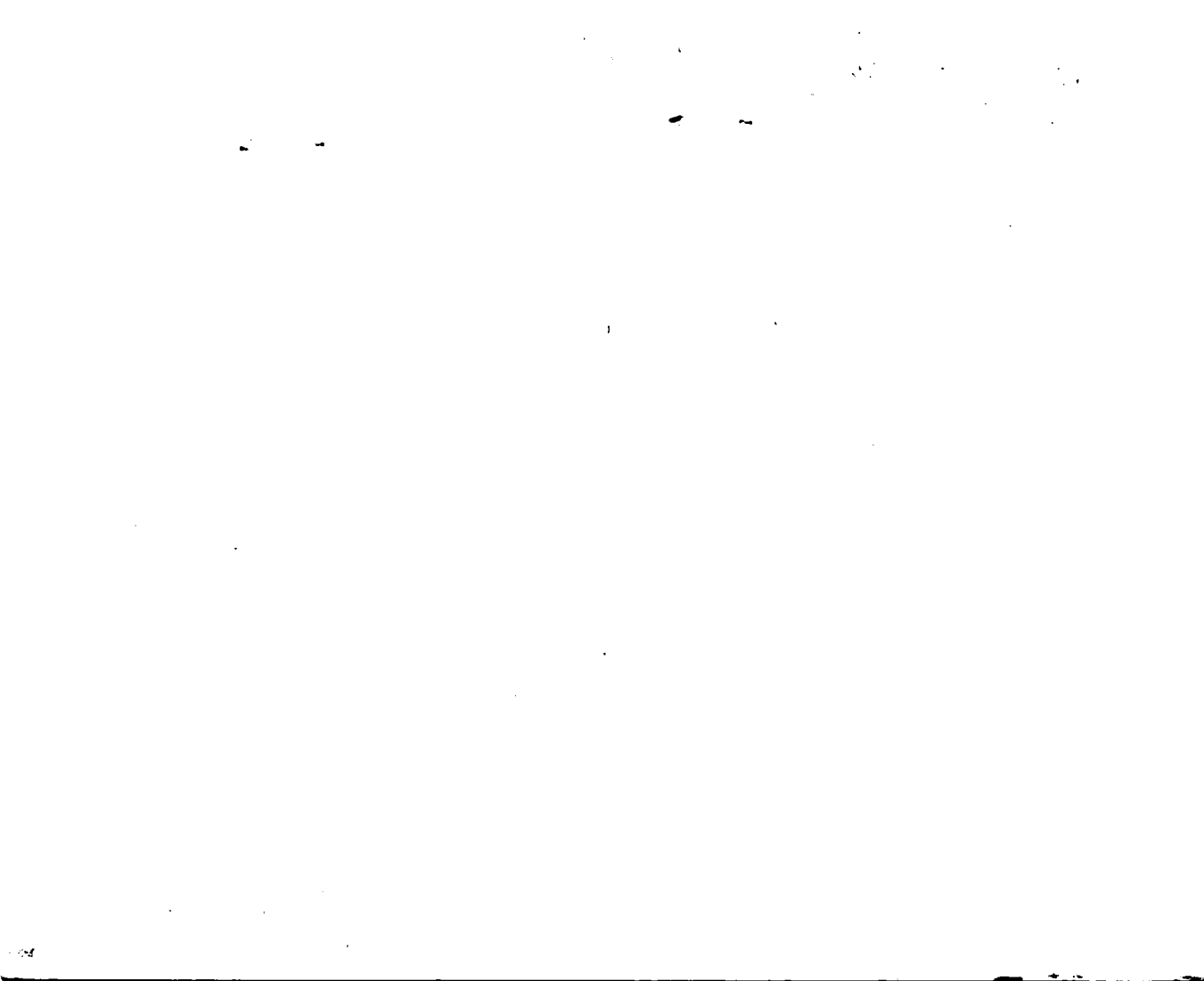
Rathdrum, Ida.

Filed

5/12 1927
W.D. Driscoll
Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 28 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **57644**

PLACE OF DEATH

County of Rathdrum
City of Rathdrum

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (un-named) Kirch Knopf

(a) Residence. No. R. R. 2. St. Rathdrum Idaho

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

16 DATE OF DEATH April 25 19 27
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1927 to Apr. 25, 1927.
that I last saw him alive on Apr. 25, 1927.
and that death occurred, on the date stated above, at 7:12 P. m.

6 DATE OF BIRTH (month, day and year) Stillborn
7 AGE Years Months Days If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:
Stillborn - difficult birth
instrumental delivery, very
large child
(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY Over gestation - about
(Secondary)
10 months (duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) Rathdrum, Idaho
(State or country)

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER John E. Kirch Knopf

Did an operation precede death? No Date of

Was there an autopsy? No

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

What test confirmed diagnosis?

(Signed) Frank H. King M. D.
4/26, 1927 (Address) Rathdrum, Idaho

12 MAIDEN NAME OF MOTHER Mary L. Shove

13 BIRTHPLACE OF MOTHER (city or town) Id
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 Informant John E. Kirch Knopf
(Address) Rathdrum, Idaho - R. 2

19 Place of Burial, Cremation, or Removal Pine Grove Cemetery - Rathdrum Date of Burial 4/26 1927

20. Undertaker Carsrud Funeral Home Address Rathdrum

15 Filed _____, 19____ Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: "Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of

City of

No. 967 214.028 249 St. Registration District No. 30 State File No.

Hospital Primary Registration District No. 05 Local Registrar's No.

CERTIFICATE OF BIRTH 52087

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? } and { Number in order of birth Legitimate? yes Date of birth Mar-14 1927 (Month) (Day) (Year)

What bactericidal solution was used in eyes? Sol. and Sol.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 2

FULL NAME FATHER Claude C. Rogers FULL MAIDEN NAME MOTHER Lela Smith

RESIDENCE Post Falls RESIDENCE Post Falls

COLOR White AGE AT LAST BIRTHDAY 24 (Years) COLOR white AGE AT LAST BIRTHDAY 19 (Years)

BIRTHPLACE Post Falls BIRTHPLACE Mo

OCCUPATION Master OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 2 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. L. McCauley

(Physician or midwife)

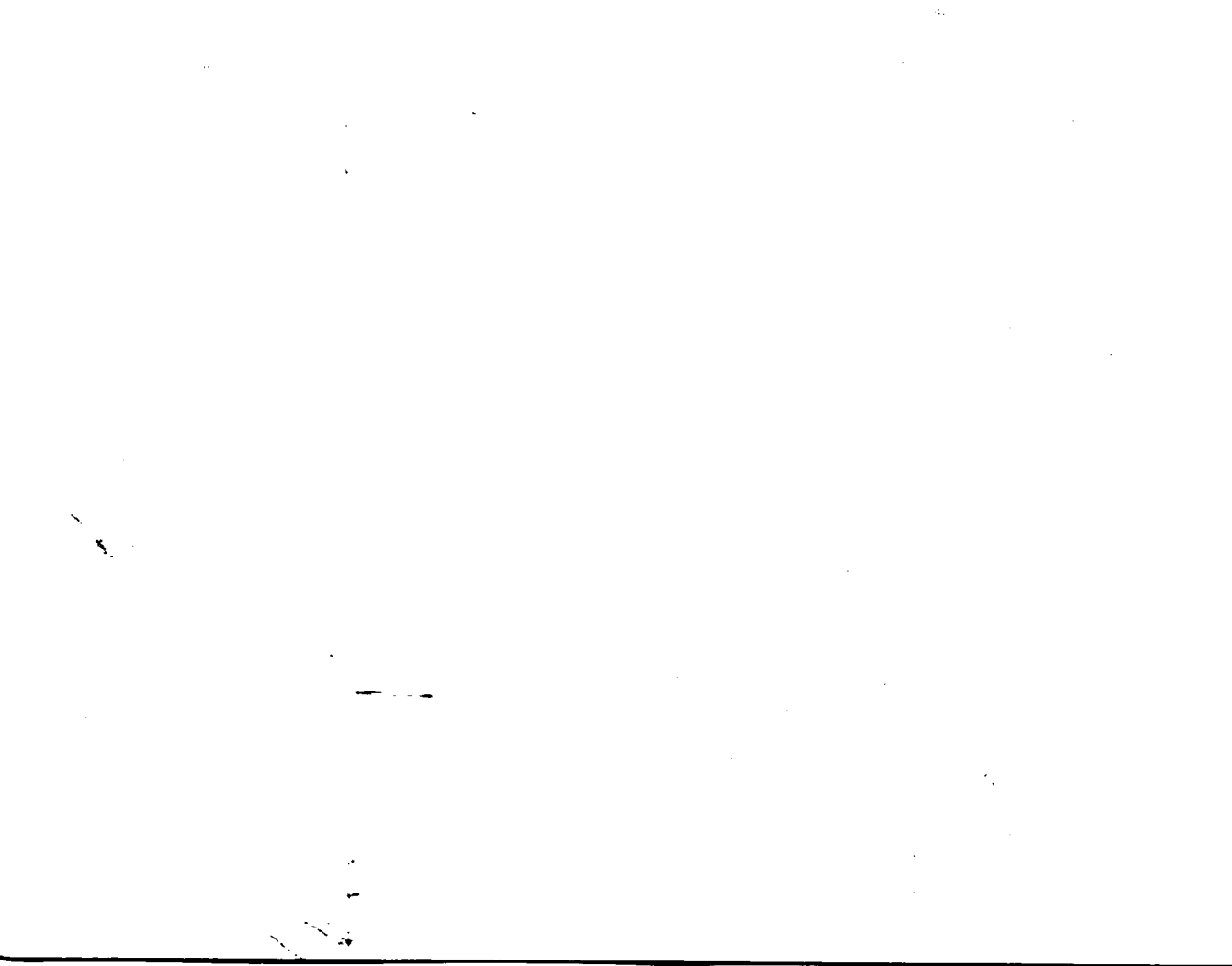
Address Post Falls, Idaho

Filed 4/27 1927

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



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N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED JUN 13 1927

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Teton

City of Boise, Idaho

CERTIFICATE OF BIRTH

No. 921128 028 632 St. Registration District No. 30 State File No. 152119

Hospital Primary Registration District No. 1037 Local Registrar's No.

FULL NAME OF CHILD Edward Isaacson

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>May 27</u> 192 <u>7</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? 10% Argolol Sol.

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FULL NAME <u>Arnold Isaacson</u>	FATHER
RESIDENCE <u>Boise, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)
BIRTHPLACE <u>Michigan</u>	
OCCUPATION <u>Furniture repairer</u>	

FULL MAIDEN NAME <u>Helma Olson</u>	MOTHER
RESIDENCE <u>Boise, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Michigan</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

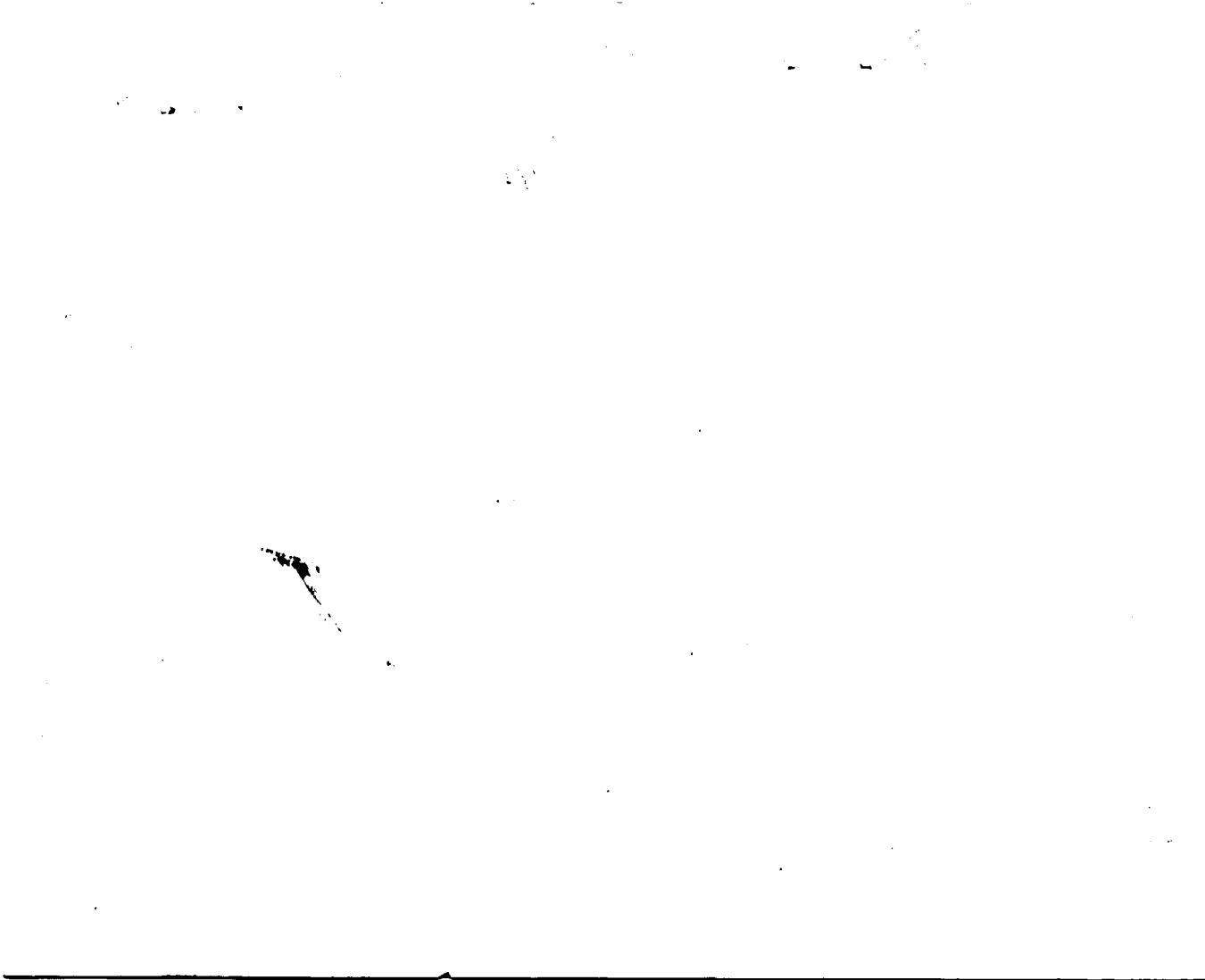
(Signature) John Albright

(Physician or midwife)

Address Boise, Idaho

Filed June 4 1927 V. E. Green Registrar.

Registrar.



RECEIVED JUN 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 57663

PLACE OF DEATH

County of Booleman
City of Boone, IdahoRegistration District No. 30
Primary Registration District No. 121
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Isaacson(a) Residence. No. 724 Lo Rende one St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) May 28 19277 AGE Years 0 Months 0 Days 0 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Boone, Idaho
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Mich.
(State or country)12 MAIDEN NAME OF MOTHER Helma Olson13 BIRTHPLACE OF MOTHER (city or town) Mich.
(State or country)14 Informant Arnold Isaacson
(Address) Boone, Idaho15 Filed May 30, 1927 L. A. F. Gunnar
M. E. J. Registrar

16 DATE OF DEATH

May 28 1927
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 28, 1927 to May 28, 1927that I last saw him alive on still born, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born.
Marginal placenta previa and
prolapse of cord.
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) John Olwood, M. D.
May 28, 1927 (Address) Boone, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19 Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial May 28 192720. Undertaker CPA Massey Address Boone, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHILE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic Interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED MAY 14 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of LemhiCity of BakerNo. 49-128030394 St.Registration District No. 41State File No. 152147

Hospital

Primary Registration District No. 2116

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
ChildmaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthApr 281927

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Lon Marsing

RESIDENCE

Baker

COLOR

whAGE AT LAST
BIRTHDAY29

(Years)

BIRTHPLACE

Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Lavern Tidwell

RESIDENCE

Baker

COLOR

whAGE AT LAST
BIRTHDAY25

(Years)

BIRTHPLACE

Utah

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.Stillborn*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

P. S. Myer

(Physician or midwife)

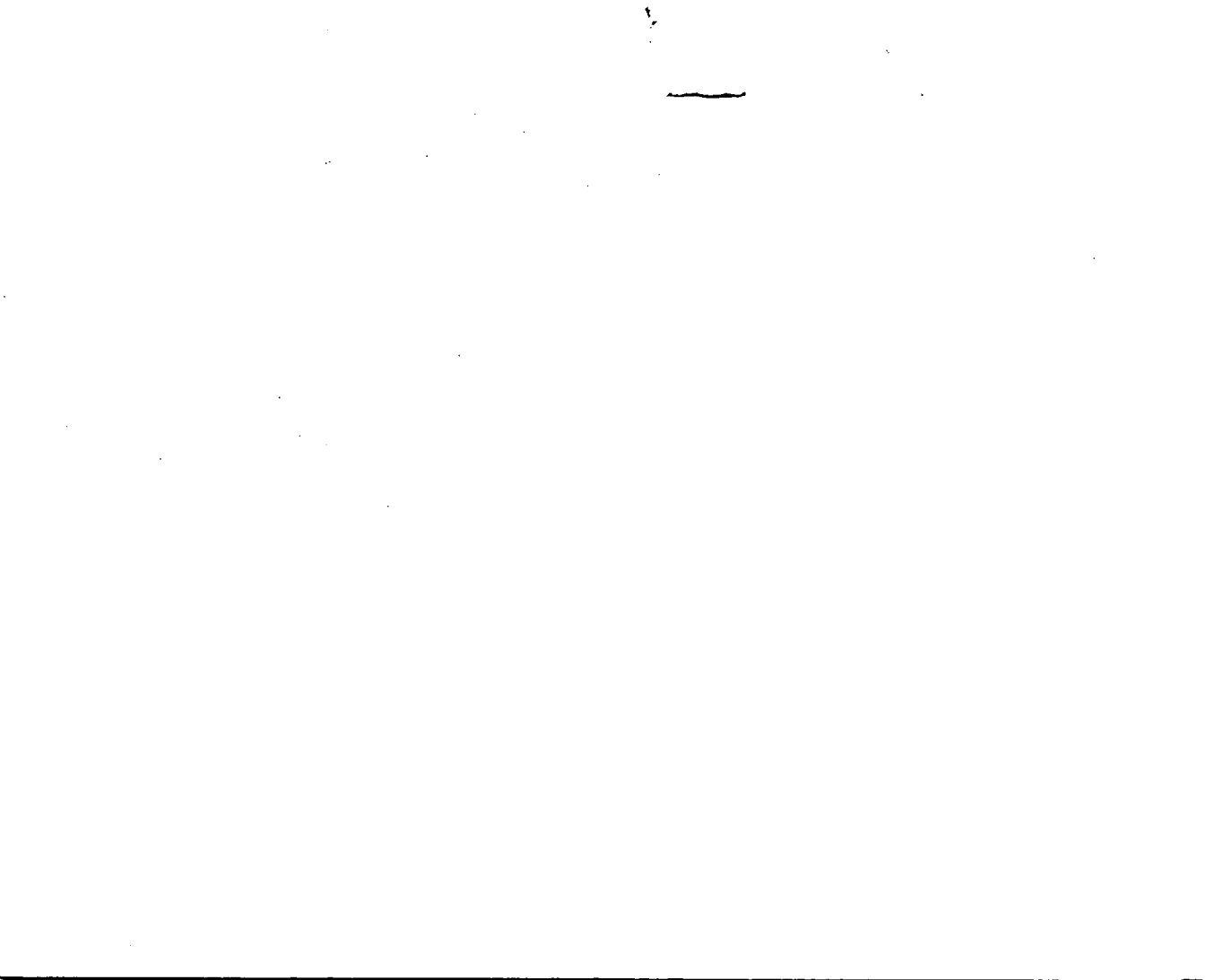
Address

SullivanFiled May 10 1927Chas. Bellman

Reg.

Registrar.

WRITE PLAINLY WITH UNFADEING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 14 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Lemhi

City of Salmon

No. 361-103030863

St.

Registration District No. 41

State File No.

152150

S

Hospital Salmon General

Primary Registration District No. 2116

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male } and { Number in order of birth }
(To be answered only in event of plural births)

Legitimate? Yes

Date of birth Apr 3 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth one

Number of child of this mother now living, including present birth one

FATHER
FULL NAME Yess L Coates

RESIDENCE Salmon

COLOR wh AGE AT LAST BIRTHDAY 30 (Years)

BIRTHPLACE Utah

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rena May Holbrook

RESIDENCE Salmon

COLOR wh AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Idaho

OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn 3 30 p M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
, 192

(Signature)

F. S. Wright M.D.

(Physician or midwife)

Address

Salmon

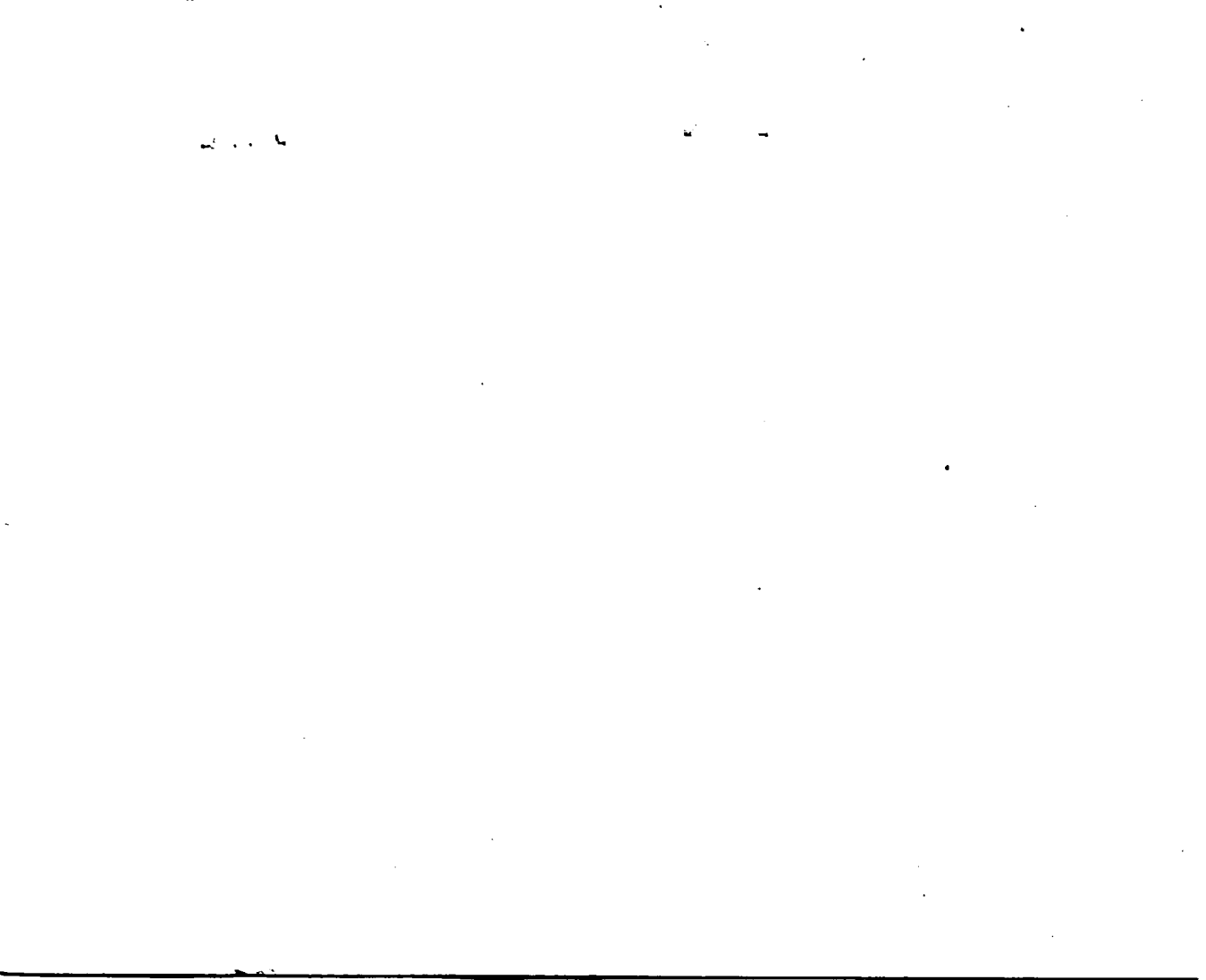
Filed

May 10 1927

Chas Bellamy

Registrar.

Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED APR 12 1927
PLACE OF DEATH

County of Sevier
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. _____)

DO NOT WRITE IN THIS SPACE

State File No. 56970

Local Registrar's No. _____

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____

(Usual place of abode)

St. _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work _____

(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant

(Address)

15 Filled

4/10

1927

Chas Bellomy

Registrar

16 DATE OF DEATH

(Month)

(Day)

1927
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____.

that I last saw h. _____ alive on _____ 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) 4/8 1927 _____ M. D.

(Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Salmon Cemetery

4-3" 1927

20. Undertaker

Address

Am C. D. Coe

Salmon

APR 28 1901

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH RECEIVED MAY 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

152187

County of Madison

City of Libbard

No. 893204033-719 St.

Registration District No. 100

State File No.

Hospital

Primary Registration District No. 2178

Local Registrar's No. 68

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>March 4 1927</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? 2% mercuric chloride

Number of child of this mother, including present birth 11

Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Herbert G. Willmore
RESIDENCE Libbard, Idaho
COLOR white AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Utah
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Angela Parker
RESIDENCE Libbard, Idaho
COLOR white AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Libbard on the date above stated. 12:40 A.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Wm. H. [unclear]

(Physician or midwife)

Address Libbard, Idaho

Filed 5/11 1927

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

NOT FOR PUBLICATION
 THIS IS A CONFIDENTIAL REPORT
 OF THE UNITED STATES DEPARTMENT OF JUSTICE
 AND IS NOT TO BE RELEASED TO THE PUBLIC
 WITHOUT THE WRITTEN PERMISSION OF THE
 ATTORNEY GENERAL

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

FATHER

MOTHER

RESIDENCE

AGE AT LAST BIRTHDAY

PHIASE

OCCUPATION

CERTIFICATE

ENDING PHYSICIAN OR SURGEON

I hereby certify that I attended the birth of this child on the date above stated.
 When the child was born, the mother was in good health and the child was born in good health.
 I have signed the birth certificate of this child and the mother's name is as stated above.
 (Give names added from a supplementary report)

Signature of Physician or Surgeon

(Printed or stamped)

Register

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICAL CONDITION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instruction on back of certificate.

RECEIVED JUN 1 1927		BUREAU OF VITAL STATISTICS		DEPARTMENT OF PUBLIC WELFARE	
PEACE OF DEATH		CITY OF HILLHARD		COUNTY OF ILLINOIS	
County of <u>Illinois</u>		Registration District No. <u>100</u>		Local Registrar's No. <u>38</u>	
City of <u>Hillhard</u>		Primary Registration District No. <u>478</u>			
(No. <u>100</u>)		(If death occurred in a hospital or institution, give its name instead of street and number.)			
2. FULL NAME <u>Phil Bon</u>					
(a) Residence. No. <u>Reburg Afd #3</u>		St. <u></u>		(If nonresident give city or town and State)	
Length of residence in city or town where death occurred. yrs. mos. ds.		How long in U. S., if of foreign birth? yrs. mos. ds.			
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>girl</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced <u>married</u>			
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u></u>					
6. DATE OF BIRTH (month, day and year) <u>Mar 4 1927</u>					
7. AGE Years <u>1</u>	Months <u>0</u>	Days <u>0</u>	If LESS than 1 day, hrs. or min. <u>still born</u>		
8. OCCUPATION OF DECEASED <u></u>					
(a) Trade, profession, or particular kind of work <u></u>					
(b) General nature of industry, business, or establishment in which employed (or employer) <u></u>					
(c) Name of employer <u></u>					
9. BIRTHPLACE (city or town) (State or country) <u>Hillhard, Idaho</u>					
10. NAME OF FATHER <u>H. G. Willmore</u>					
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Logan</u>					
12. MAIDEN NAME OF MOTHER <u>Mary D Parker</u>					
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Reburg</u>					
14. Informant <u>H. G. Willmore R. J. Ray</u>					
(Address) <u></u>					
15. Filed <u>17</u> 1927 <u>11/17/27</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>March 4</u> 1927 (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>March 4</u> , 1927, to <u>March 4</u> , 1927, that I last saw her alive on <u>Street</u> , 1927, and that death occurred, on the date stated above, at <u>12</u> m. The CAUSE OF DEATH* was as follows: <u>Strangulation of umbilical cord.</u>					
(duration) yrs. mos. ds. <u>1</u> ds.					
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. <u></u>					
18. Where was disease contracted if not at place of death? <u></u>					
Did an operation precede death? <u>no</u> Date of <u></u>					
Was there an autopsy? <u>no</u>					
What test confirmed diagnosis? <u></u>					
(Signed) <u>John S. Fisher</u> M. D. <u>5-18</u> 1927 (Address) <u>Reburg, Idaho</u>					
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
19. Place of Burial, Cremation, or Removal <u>Reburg</u> Date of Burial <u>3/4</u> 1927					
20. Undertaker <u></u> Address <u></u>					

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Steno-grapher, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

152196

County of Madison
City of Rephung

No. 514-117033-566 St.

(If born in hospital or institution
give name.)

Registration District No. 100 State File No.

Prim. Registration District No. 2-178 Local Registrar's No. 67

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet <u>One</u> and or other? <u>—</u>	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Apr 17</u>	1927
				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 10 cc. ergol.

Number of child of this mother, including present birth 9 (a) Born alive and now living

Born alive but now dead — Stillborn —

FATHER FULL NAME <u>G. A. Handal</u>	MOTHER FULL MAIDEN NAME <u>Lillian Young</u>
---	---

Residence (Usual place of abode) Rephung, Ida.

If nonresident, give place and State —

Color or race White Age at last Birthday 39

Birthplace Utah (Years)

Occupation Mail Carrier

Residence (Usual place of abode) Rephung

If nonresident, give place and State —

Color or race White Age at last Birthday 37

Birthplace Idaho (Years)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 5:30 A. M.
on the date above stated.

(Signature) G. P. Carpio

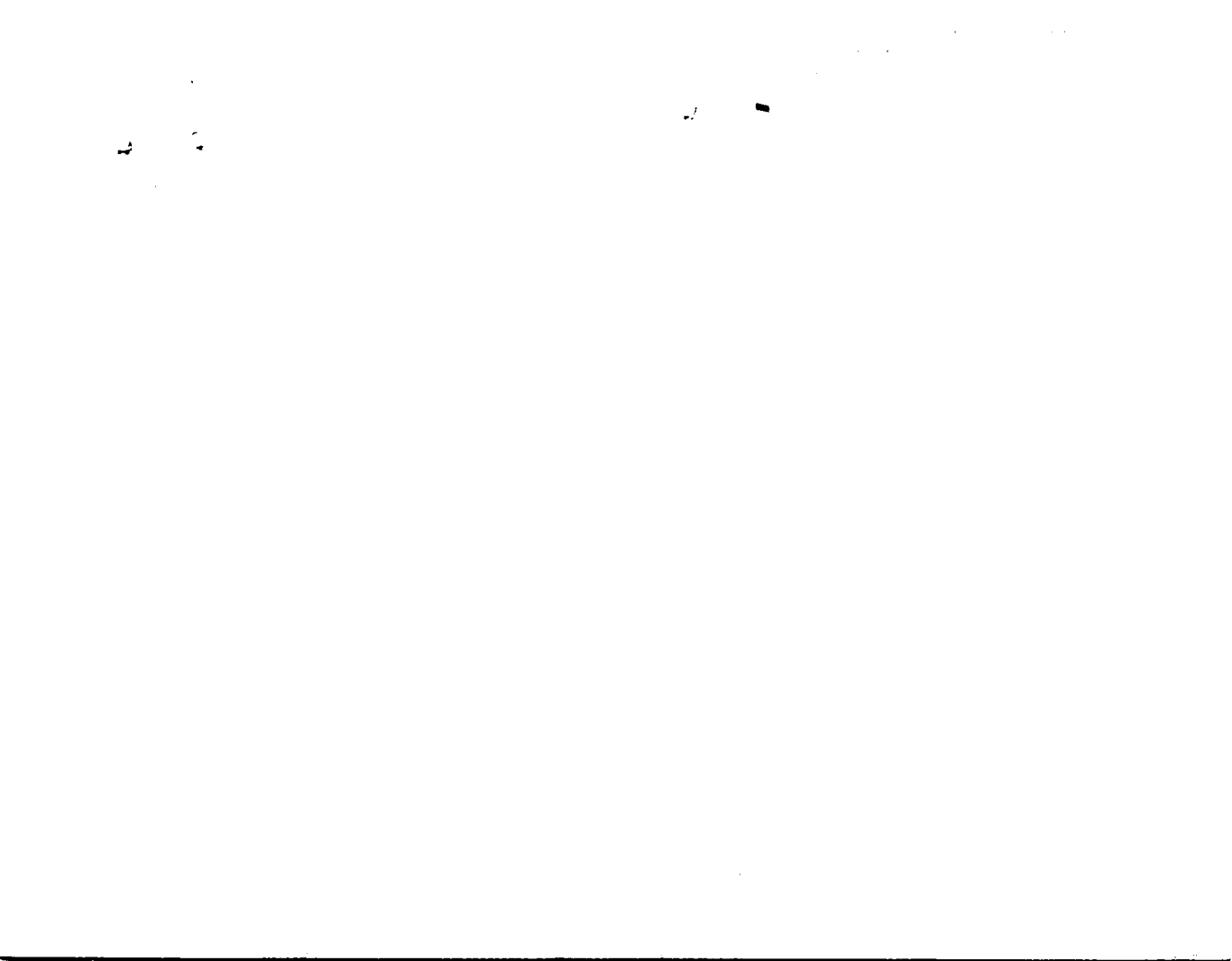
(Physician or midwife)

Address Rephung, Ida.

Filed 5-15 1927 Young

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 52704

Local Registrar's No. 32

PLACE OF DEATH
County of Madison
City of Boise

Registration District No. 100
Primary Registration District No. 2178

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stille Born

(a) Residence. No. Main St. Boise St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Mar.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17 - 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida
(State or country)

10. NAME OF FATHER G. C. Maudsall

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Lillian Young

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Dr. Parkinson
(Address) Boise

15. Filed 4/30, 1927 J. R. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17/27, 1927, to 4/17, 1927
that I last saw him alive on 4/17, 1927

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia with
small embolism

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) W. J. Parkinson, M. D.
4/19, 1927 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Boise Date of Burial 4/18, 1927

20. Undertaker Howe Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAY 12 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka

City of Rupert, Idaho

No. 234-224034-697

Registration District No. 19

State File No. 152246

Hospital

Primary Registration District No. 2013

Local Registrar's No. 67

FULL NAME OF CHILD

Agnes Studer

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

4 - 24 - 1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL NAME

FATHER

Anton Studer

RESIDENCE

Rupert, Idaho

COLOR

white

AGE AT LAST BIRTHDAY

33
(Years)

BIRTHPLACE

Ohio

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Katie Wippenhiser

RESIDENCE

Rupert, Idaho

COLOR

white

AGE AT LAST BIRTHDAY

31
(Years)

BIRTHPLACE

Germany

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Delbert Frazier, MD

(Physician or midwife)

Address

Rupert, Idaho

Filed

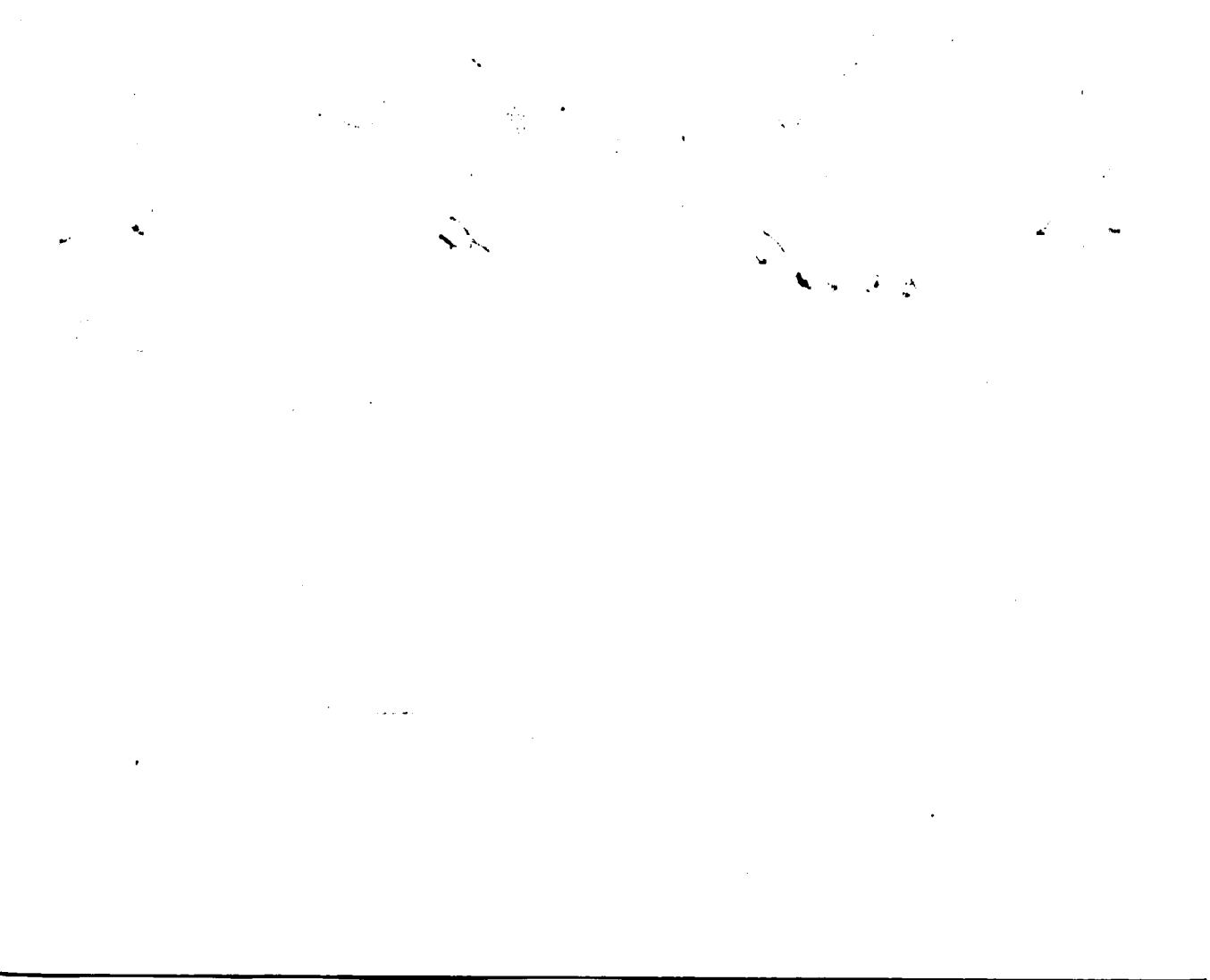
5-3-1927

1927

E. H. E. Hoover

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF BIRTH **RECEIVED NOV 9 1927**
 County of Blundage Registration District No. 19
 City of Rupert Primary Registration District No. 2015
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine Studer

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 59334
 Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Apr 23 1927
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Andy Studer

11. BIRTHPLACE OF FATHER

(State or Country) Ohio12. MAIDEN NAME OF MOTHER Katie Wikenkiser

13. BIRTHPLACE OF MOTHER

(State or Country) Baden Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andy Studer(Address) Rupert Idaho

15. Filed

Nov 4 1927

E. E. Johnson
 Local Registrar

16. DATE OF DEATH

Apr 23 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1927, to Apr 24 1927, that I last saw him alive on 19, and that death occurred on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn (See probing to severe prolonged labor.)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Isabel Frazin M. D.19. (Address) Rupert, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. A. Goodman Apr 23 1927

20. UNDERTAKER

ADDRESS

City Council Rupert Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED MAY 18 1927 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Nez Perce
City of Lewiston
No. 35105035192 St. Registration District No. 96 State File No. S
Hospital St. Joseph Primary Registration District No. 1009 Local Registrar's No. S
FULL NAME OF CHILD Still Born McEvers

CERTIFICATE OF BIRTH 152325

(Certificate of no value without full name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>✓</u> and { Number in order of birth <u>✓</u>	Legitimate? <u>Yes</u>	Date of birth <u>Apr 5</u> 1927 (Month) (Day) (Year)
------------------------	---	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Joseph Clark McEvers
RESIDENCE Lewiston Ida
COLOR W. AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Nash.
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Mayis Justen Aiken
RESIDENCE Lewiston Ida
COLOR W. AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Okla
OCCUPATION Styler

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 10 P M. on the date above stated.

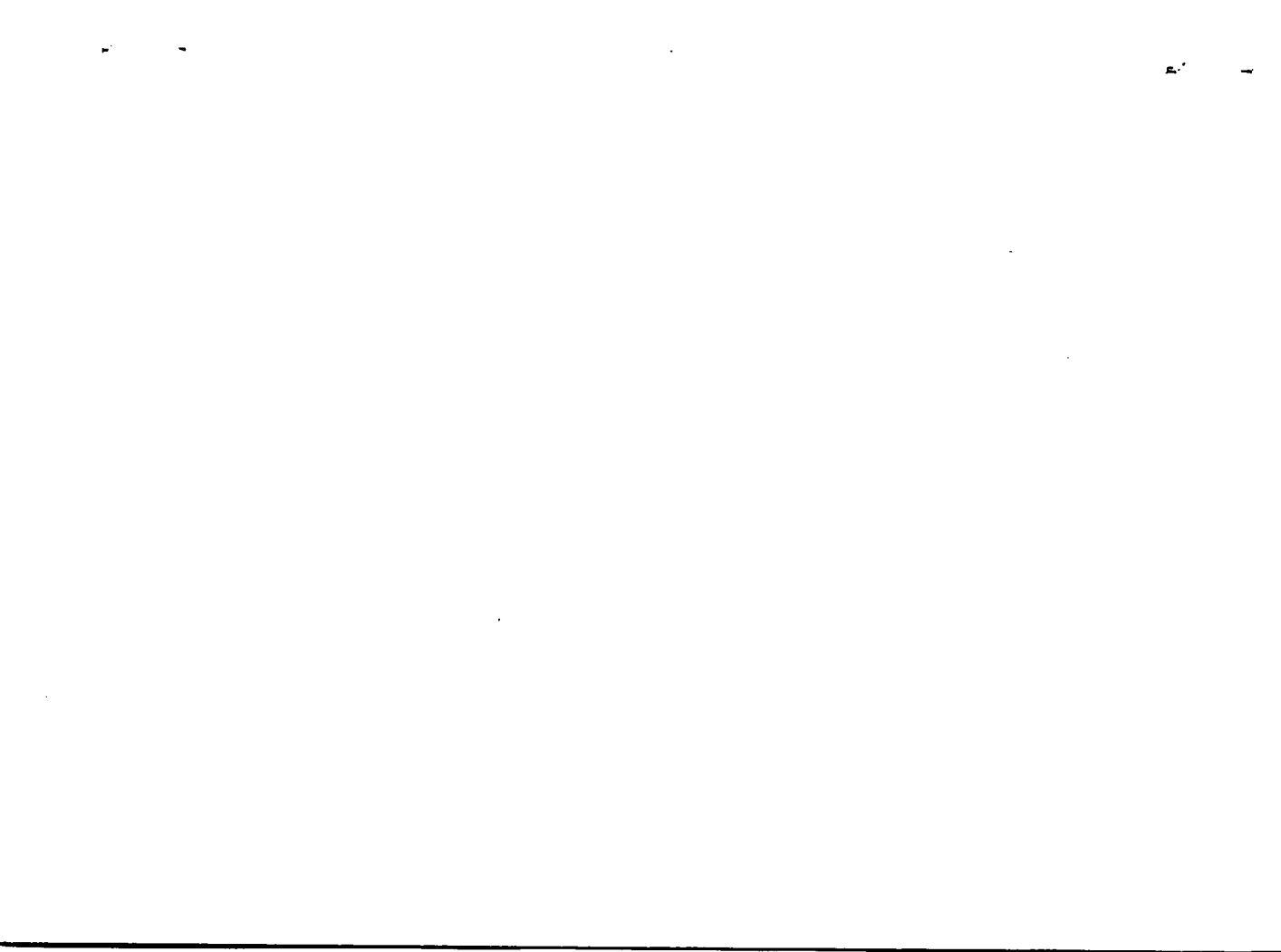
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. H. Locksley
Physician
(Physician or midwife)

Address Lewiston Ida

Filed May 10 1927 Dean E. Bruce Registrar.

Registrar.



WHILE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 18 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57721

Local Registrar's No.

County of Blaine
City of Lewiston, Ida

Registration District No. 96
Primary Registration District No. 1009
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Joseph McEvers

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

4/5/1927

7 AGE

Years _____ Months _____ Days _____

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lewiston, Ida.

10 NAME OF FATHER

Joe C. McEvers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Springdale, Wash.

12 MAIDEN NAME OF MOTHER

Mabel Aiken

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pawhuska, Oklahoma

14 Informant

(Address)

Joe C. McEvers
Gratop, Ida.

15 Filed

May 10, 1927

Susan E Bruce

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April
(Month)

5
(Day)

1927
(Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1927 to Apr. 5, 1927

that I last saw him alive on Thursday, Apr. 5, 1927

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Stroke

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No Date of ✓

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

L. H. Blackburg

M. D.

Apr 6, 1927

(Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Clackston, Wash

3/6 1927

20. Undertaker

Address

H. R. Muchant

Clackston, Wash

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number; beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

365 709 059 393
PLACE OF BIRTH
of P.O. Box
American Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

152347

Registration District No. 25 State File No. 100

Prim. Registration District No. 2072 Local Registrar's No. 100

FULL NAME OF CHILD Still born (Tosus)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>May 9</u> (Month) (Day) (Year) <u>1927</u>
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 8 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 3

FATHER
FULL NAME John E. Tosus
Residence (Usual place of abode) Aberdeen, Ida
If nonresident, give place and State. —
Color or race White Age at last Birthday 38
Birthplace Newton, Kansas (Years)
(City and State or Country)
Occupation Merchant

MOTHER
FULL MAIDEN NAME Nelle Lichtenheld
Residence (Usual place of abode) Aberdeen, Ida
If nonresident, give place and State. —
Color or race White Age at last Birthday 42
Birthplace Oskaloosa, Iowa (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 3 A. M.
on the date above stated. { Stillborn }

(Signature) M. C. Merriam, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Physician or midwife
Address Aberdeen, Ida
Filed 6-6 1927 Genevieve Roth
Registrar.



1

2

RECEIVED JUN 10 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Power*

Registration District No.

City of *American Falls*

Primary Registration District No.

(No. *Bethany Hospital* St.)File No. *57734*Registered No. *313*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born (Toarus)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*male white**Single*
(Write the word.)

6. DATE OF BIRTH

May - 9 1927
(Month) (Day) (Year)

7. AGE

*0 Yrs. 0 Mos. 0 ds.*IF LESS than 1 day
how many *0* hrs.
or *0* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John E Toarus

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Nele Lichtenheld

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Toarus

(Address)

Aberdeen Idaho

15.

Filed *6-6* 19 *27**Junius Nolt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

*Still birth - at term -
Cerebral injuries during
delivery -*
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *M. C. Markinson* M. D.*5/9 1927* (Address) *Aberdeen Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Aberdeen Idaho**5-10 1927*

20. UNDERTAKER

ADDRESS

Friends

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

376-2180408/4
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Shoshone JUN 3 1927
City of Hellog
No. 7. E. Camacho St. Registration District No. 123 State File No. 152364
Hospital _____ Primary Registration District No. 330 Local Registrar's No. 52
FULL NAME OF CHILD Barbara Croghan
(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? _____ and { Number in order of birth _____ } Legiti- mate? yes Date of birth 3/18/1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none
Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Wm Carroll Croghan
RESIDENCE Hellog, Idaho
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Wyoming
OCCUPATION miner

MOTHER
FULL MAIDEN NAME Bessie Hamilton
RESIDENCE Hellog, Idaho
COLOR white AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Montana
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) A. S. Eugene Douglas
Physician
(Physician or midwife)

Address Hellog, Idaho
Filed May 30 1927 Miss Helene M. Brade
Registrar.

1. 1. 1. 1.

1. 1. 1. 1.

1. 1. 1. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH? **RECEIVED APR 6 1927**
County of Shoshone Registration District No. 123
City of Steellog Primary Registration District No. 2211
(No. _____ St.)

State File No. 57026
Local Registrar's No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Croghan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

Mar 18 1927
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day how many
_____ hrs. or min.?
Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country) Steellog, Ida

10. NAME OF FATHER

W. C. Croghan

11. BIRTHPLACE OF FATHER

(State or Country) Wyoming

12. MAIDEN NAME OF MOTHER

Bessie Hamilton

13. BIRTHPLACE OF MOTHER

(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Croghan

(Address)

Steellog, Idaho

15.

Filed Mar 21 18 1927 W. C. Croghan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/18/1927 to 3/18/1927

that I last saw him stillborn 1927, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Monstrosity
Hydrocephalus &
spina-bifida.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. S. Macdonald M. D.

3/18/1927 (Address) Steellog, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Steellog, Ida Mar 18 1927

20. UNDERTAKER

Mr. Thornhill Steellog, Ida

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

FACE OF BIRTH

RECEIVED

Twin Falls
Twin Falls

IDAHO
PUBLIC WELFARE
STATISTICS

S

OF BIRTH 152401

No. 235 708042-379 Registration District No. 67 State File No. 1927

Hospital E. F. Co. & Son Primary Registration District No. 1085 Local Registrar's No. 1927

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>4 - 8</u> <u>1927</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME George Steinmetz
RESIDENCE Eden, Ida R.R. #9
COLOR white AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Russia
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Minnie Triple
RESIDENCE Eden, Ida, R.R. #1
COLOR white AGE AT LAST BIRTHDAY 17 (Years)
BIRTHPLACE Russell, Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{born alive} at 3:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

Q1
3



CHIR

folgado

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

PLACE OF DEATH

CERTIFICATE OF DEATH

State File No. 57778

County of Twain Falls Registration District No. 37

City of Eden Primary Registration District No. 1085

Local Registrar's No. 47

(No. Co. Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence No. Eden R.F.D. #1 St.

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year)

April 8 1927

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

16 DATE OF DEATH

April 8 1927
(Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from

Apr 8, 1927, to Apr 8, 1927.

that I last saw him alive on Apr 8, 1927.

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Intrauterine asphyxiation due to obstruction of Cord. (duration) about 2 ds.

CONTRIBUTORY

(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. M. Warrick, M. D.

Apr 8 1927 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9 BIRTHPLACE (city or town) Twain Falls
(State or country) Idaho

10 NAME OF FATHER

George Steinmetz Jr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Minna Trupple

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Iowa

14 Informant Geo. Steinmetz Jr.

(Address)

Eden Idaho

15 Filed 5-10, 1927 John S. Gughen Registrar

19 Place of Burial, Cremation, or Removal

Date of Burial

Twain Falls

April 9 1927

20. Undertaker

P. J. Grossman Twain Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED JUN 16 1927
PLACE OF BIRTH 693105 003 '231
County of Dennock
City of Pocatello
No. 440 N. Lincoln St. Registration District No. 28 State File No. 152563
Hospital ✓ Primary Registration District No. 2161 Local Registrar's No. 8152
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)
Sex of Child male Twin Triplet or other? ✓ and { Number in order of birth 5 Legitimate? yes Date of birth 4-5 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Ray Williams
RESIDENCE Pocatello Idaho
COLOR wh AGE AT LAST BIRTHDAY 34
(Years)
BIRTHPLACE Utah
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Kelly Blair
RESIDENCE same
COLOR wh AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Utah
OCCUPATION wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn ✓ 830 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

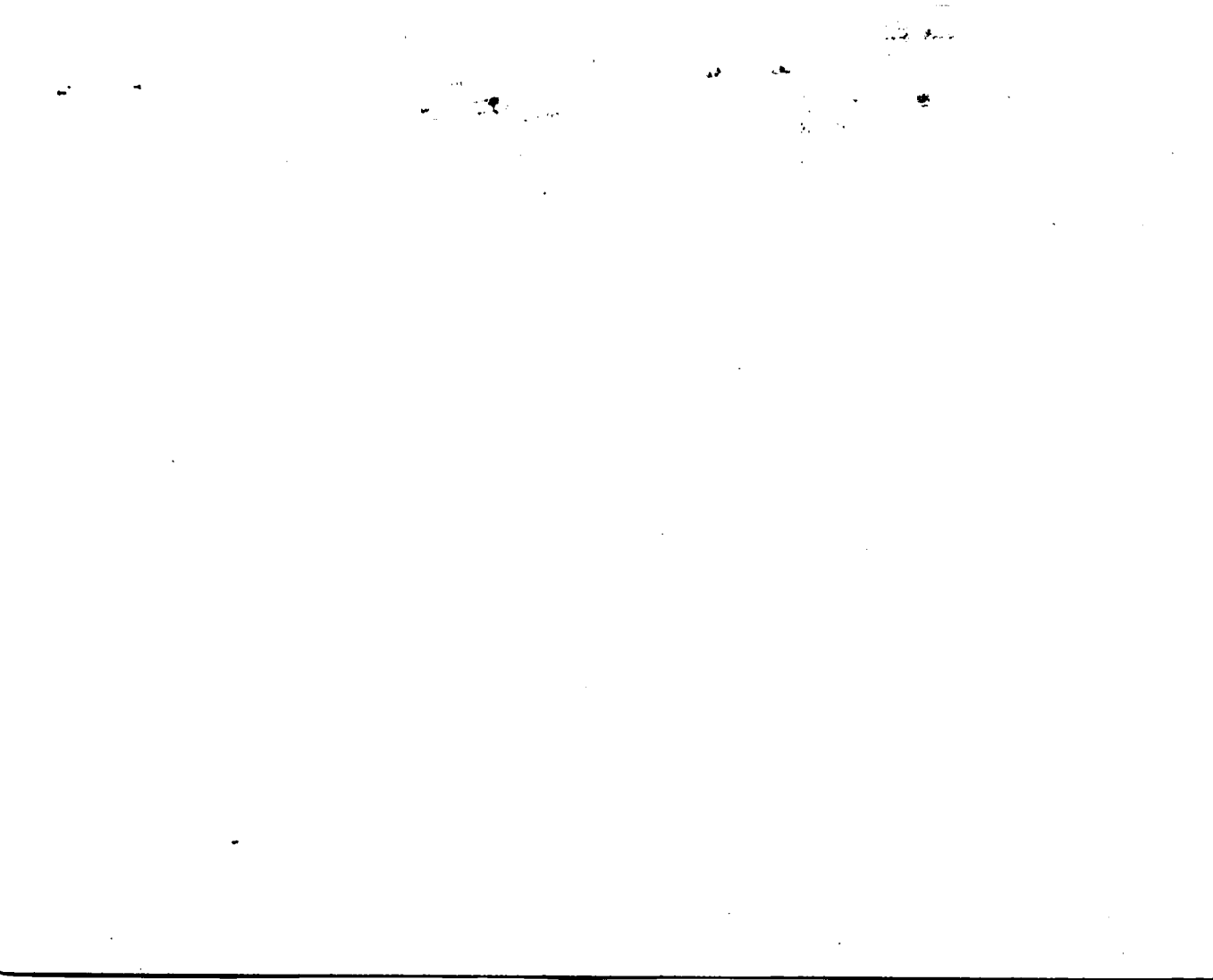
(Signature) D. C. Ray

(Physician or midwife)

Address Pocatello, Idaho

Filed 6/1 1927 Monroe Registrar.

Registrar.



MAINTAIN RECORD FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **57388**

RECEIVED MAY 20 1927
PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28

Primary Registration District No. 2461

(No. 440 - North Lincoln)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5023

2. FULL NAME Infant Williams

(a) Residence. No. 440 - North Lincoln St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5 - 1927

7. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello (State or country) Idaho

10. NAME OF FATHER Ray Williams

11. BIRTHPLACE OF FATHER (city or town) Lewiston (State or Country) Utah

12. MAIDEN NAME OF MOTHER Pella Blair

13. BIRTHPLACE OF MOTHER (city or town) Lewiston (State or Country) Utah

14. Informant Ray Williams (Address) Pocatello Idaho

15. Filed 4/6, 1927. J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1927, to Apr 5 1927

that I last saw him alive on 1927

and that death occurred, on the date stated above, at 1927 m.

The CAUSE OF DEATH* was as follows:

Stillborn Premature
by drocephalus very
large.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no further

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Ray M. D.
4-6 1927 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Mountain View Cem April 1927

20. Undertaker Address

Schumacher & Hall Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

753-102-003866

County of Bannock

City of Swann Lake

No. St. Registration District No. 8-3 State File No. 152591

Hospital Primary Registration District No. 2160 Local Registrar's No. 292

FULL NAME OF CHILD.....

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>May, 2, 1927</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 5

FULL NAME FATHER
Lewis J. Petty Jr.

RESIDENCE
Swann Lake, Idaho

COLOR White AGE AT LAST BIRTHDAY 47
(Years)

BIRTHPLACE Utah

OCCUPATION
Farming

FULL MAIDEN NAME MOTHER
Edith Chellia Howell

RESIDENCE
Swann Lake, Idaho

COLOR White AGE AT LAST BIRTHDAY 41
(Years)

BIRTHPLACE
Idaho

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 10:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

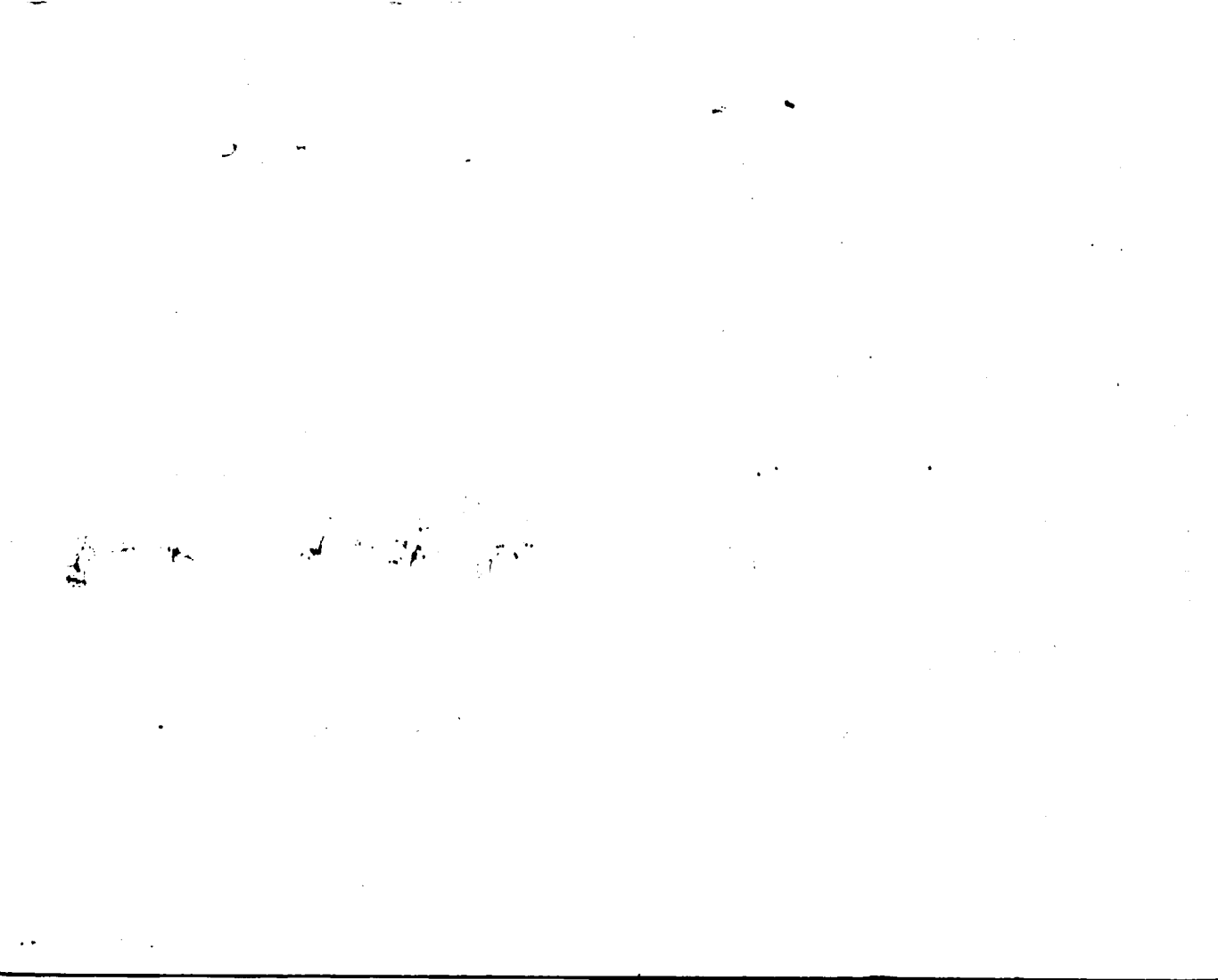
Registrar.

(Signature)

Physician
(Physician or midwife)

Address Preston, Idaho

Filed May-9-1927 Mary C. Coffin
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of Bannock
City of Swan Lake
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 83
Primary Registration District No. 2160
(No. _____ St.)
2. FULL NAME Stillborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 57861
Local Registrar's No. 69
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)
6. DATE OF BIRTH May 2, 1927
(Month) (Day) (Year)
7. AGE 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE (State or Country) Swan Lake, Idaho
10. NAME OF FATHER Lewis J. Petty Jr.
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Edita Chella Howell
13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis J. Petty Jr.
(Address) Swan Lake, Idaho
15. Filed May - 9 - 1927 Mary C. Coffey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2, 1927
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 2, 1927 to May 2, 1927
that I last saw him alive on _____
and that death occurred on the date stated above, at _____
The CAUSE OF DEATH* was as follows:
undetermined
probably toxemia of pregnancy
of mother
(Duration) yrs. mos. ds.
Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) Ed. Chella Howell M. D.
5.3.1927 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Swan Lake, Idaho DATE OF BURIAL _____
20. UNDERTAKER ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear LakeCity of St CharlesNo. 3 391102004695Registration District No. 55 State File No. 152678

Hospital

Primary Registration District No. 2134 Local Registrar's No. 41

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child MaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate? YesDate of
birthApr 21927

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6Number of child of this mother now living, including present birth 5FULL
NAME

FATHER

Chester O Transum

RESIDENCE

St Charles

COLOR

White

AGE AT LAST

BIRTHDAY

36
(Years)

BIRTHPLACE

Idaho

OCCUPATION

farmerFULL
MAIDEN
NAME

MOTHER

Agnes F Hurdley

RESIDENCE

St Charles

COLOR

White

AGE AT LAST

BIRTHDAY

30
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 3.05 M.
on the date above stated.*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) stillborn(Physician or midwife) Paris Idaho

Address

Filed

192

Registrar.

Registrar.

CONFIDENTIAL

581

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED JUL 11 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

386-207005-1927
County of Blaine

City of St. Maries, Ida.

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 32 State File No. 152637
Hospital S. Platt Primary Registration District No. 2049 Local Registrar's No. 48

FULL NAME OF CHILD Jane Helorus Thomas
(Certificate of no value without full name of child)

Sex of Child ♀ Twin Triplet or other? — and { Number in order of birth — Legitimate? yes Date of birth 6-7-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>John R. Thomas</u>	<u>St Maries, Ida.</u>	<u>Ida E. Arch</u>	<u>St Maries, Ida.</u>
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Truck Driver</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:50 a. m.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927
Address St Maries Ida
Filed July 8 1927 Blaine
Registrar. Registrar.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CITY OF NEW YORK
COUNTY OF NEW YORK
REGISTRATION DISTRICT NO. 1
LOCAL REGISTRATION NO. 1
1925

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CITY OF NEW YORK
COUNTY OF NEW YORK
REGISTRATION DISTRICT NO. 1
LOCAL REGISTRATION NO. 1
1925

Registration District No. 1
Local Registration No. 1
1925

NAME OF CHILD
Sex of Child
Date of Birth
Place of Birth
Occupation
Color
Birthplace
Occupation

What pathological condition was found in child?
Number of child of this mother born and present birth
Name of child of this mother born and present birth
MOTHER
FATHER
FULL NAME
RESIDENCE
COLOR
BIRTHPLACE
OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was (Males) (Females) (Both) (None)
on the date above stated.
When there was no attending physician or midwife, then the father, householder, or other person present at the birth should make this report. A statement that is one of these should be made as soon as possible after the birth of the child.
Give name of child in a denominational report
1925

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 11 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57877

County of Bennett

Registration District No. 32

City of St. Marie

Primary Registration District No. 2049

Local Registrar's No. 26

(No. Platts Shop)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Helarius Thomas

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) _____

16 DATE OF DEATH June 7 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 4:30 p. m. The CAUSE OF DEATH* was as follows:
Stillborn

6 DATE OF BIRTH (month, day and year) June 7 - 1927
7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (city or town) St. Marie
(State or country) Ida

18 Where was disease contracted
If not at place of death? _____

10 NAME OF FATHER John R. Thomas

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) Lorra
(State or country) _____

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER Ida E. Arch

What test confirmed diagnosis? O.D. Platt
(Signed) _____, M. D.

13 BIRTHPLACE OF MOTHER (city or town) Ida
(State or country) _____

June 7, 1927 (Address) St. Marie, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant John R. Thomas
(Address) St. Marie, Ida

19 Place of Burial, Cremation, or Removal W. A. A. A. A. Date of Burial June 11 1927

15 Filed June 7, 1927 Platts
Registrar

20 Undertaker Mitchell & Meraqu Address St. Marie, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
152731

County of Bingham

City of Blackfoot

No. 389-111006-386 St. Registration District No. 121 State File No.

Hospital Primary Registration District No. 2194 Local Registrar's No. 209

FULL NAME OF CHILD James Christensen Jr.

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> } and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>6/11/27</u> 192 <u>7</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? Neo-Silvol 10%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME James Christensen
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Denmark
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Margaret Nelson Thamsen
RESIDENCE Blackfoot
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at Blackfoot on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. O. Humphreys

(Physician or midwife)

Address Blackfoot, Idaho

Filed July 5 1927

Registrar.

Registrar.

CHARGE OF THE CHILD TO THE FATHER OR MOTHER OR TO THE STATE OF MISSOURI
 If the child is born to a married couple, the father and mother shall be charged with the child.
 If the child is born to an unmarried woman, the mother shall be charged with the child.
 If the child is born to a woman who is not married and who is not the mother of the child, the child shall be charged to the state of Missouri.

STATE OF MISSOURI
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Hospital _____
 Primary Registration District No. _____
 Registration District No. _____

KIND NAME OF CHILD _____
 (Certificate of no living without full name of child)

Sex of _____
 Child _____
 (To be signed by only in case of female child)
 Date of birth _____
 (Month) (Day) (Year)

No. 211-101

What pathological condition was used in _____
 Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____

MOTHER

FATHER

Blackfoot

Blackfoot

COLOR

AGE AT LAST BIRTHDAY

White

White

BIRTHPLACE

Blackfoot

Missouri

OCCUPATION

Farmer

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.

When there was no attending physician or midwife, then the father, householder or neighbor, make this return. A stillborn child is one that neither breathed nor shows other evidence of life after birth. Give names taken from a supplemental report.

(Physician or midwife)

Address

Filed

Registered

Registered

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 57892

Local Registrar's No. 86

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bingham
City of Bluff

Registration District No. 121
Primary Registration District No. 2194
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Christensen Jr.

(a) Residence. No. 1200 S. 1st St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Idaho
(State or country)

10 NAME OF FATHER James Christensen

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant James Christensen
(Address)

15 Filed June 11 1927 Mo Waters & Paine
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 11 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1927, to _____, 19____.
That I last saw him alive on _____, 19____.
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

slight burn, Joseph delivery due to obstetrical complications.
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?
(Signed) G. O. Humphreys, M. D.
6-11-27 1927 (Address) Bluff

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Home of cemetery June 11 1927

20. Undertaker E. L. Luck Address Bluff

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCounty of Benner RECEIVED JUL 5 1927City of Sandpoint Idaho

CERTIFICATE OF BIRTH

No. 791124009 495 St. Registration District No. 78 State File No. 152765Hospital Page Primary Registration District No. 2155 Local Registrar's No. _____FULL NAME OF CHILD Baby Graves

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	} and {	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>June 24</u> <u>1927</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 0 Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Lawrence B Graves

RESIDENCE

Sandpoint Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY 21
(Years)

BIRTHPLACE

Ludington Wis.

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Madeline Drew

RESIDENCE

Sandpoint Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY 18
(Years)

BIRTHPLACE

Sandpoint Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn 5.30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Sandpoint IdahoFiled July 2 1927Viola Allen
[Signature] Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 57912

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. 512 M. Second. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Infant Grames
(a) Residence. No. 3201 H. Clark
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE <u>Stillbirth</u>	Years <u>Full term</u>	Months <u>min.</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

PARENTS

9. BIRTHPLACE (city or town) (State or country) <u>Sandpoint Idaho</u>	10. NAME OF FATHER <u>Laverne B. Grames</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Ladysburg Wisconsin</u>	12. MARRIED NAME OF MOTHER <u>Madeline Drexler</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>	14. Informant <u>Laverne B. Grames</u> (Address) <u>Sandpoint Idaho</u>
15. Filed <u>June 24, 1927</u>	<u>Violet Allen</u> Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 24 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 24, 1927, to
that I last saw him alive on
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:
Stillborn due to difficult labor
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted
if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. J. Ross M. D.
June 24, 1927 (Address) Sandpoint
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal Date of Burial
Laverne Cemetery June 24, 1927
20. Undertaker Address
Turnbull Co Sandpoint

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the **fifth of the following month**; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED JUN 25 1927**
666 125 010 493
County of **Bonneville**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of **Idaho Falls, Idaho.**

CERTIFICATE OF BIRTH

152786

No. **73** St. Registration District No. **215** State File No. **215**

Hospital **L. D. S. H.** Primary Registration District No. **215** Local Registrar's No. **215**

FULL NAME OF CHILD (Stillborn) **Wood,**

(Certificate of no value without full name of child)

Sex of Child Male	Twin Triplet or other? --- and { Number in order of birth ---	Legitimate? Yes	Date of birth May 25, 1927
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? **None**

Number of child of this mother, including present birth **4** Number of child of this mother now living, including present birth **0**

FATHER

FULL NAME
Harry T. Wood

RESIDENCE

Idaho Falls, Idaho.

COLOR

white

AGE AT LAST BIRTHDAY **45**

(Years)

BIRTHPLACE

Iowa

OCCUPATION

Dentist

FULL MAIDEN NAME

MOTHER
Theama L. Rice

RESIDENCE

Idaho Falls, Idaho.

COLOR

white

AGE AT LAST BIRTHDAY **26**

(Years)

BIRTHPLACE

Victor, Idaho.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was **Born alive** **Stillborn** at **1:15 P.M.** on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address **Idaho Falls, Idaho.**

Filed **6/6** 192 **7**

Registrar.

Registrar.

1. Name of child
 2. Sex
 3. Date of birth
 4. Place of birth
 5. Name of mother
 6. Name of father
 7. Name of attending physician
 8. Name of hospital
 9. Name of registrar
 10. Name of certifier
 11. Name of certifier's address
 12. Name of certifier's telephone
 13. Name of certifier's occupation
 14. Name of certifier's date of birth
 15. Name of certifier's sex
 16. Name of certifier's place of birth
 17. Name of certifier's name
 18. Name of certifier's name
 19. Name of certifier's name
 20. Name of certifier's name

Give names of all persons who have been in contact with the child since birth, including the mother, father, and all other persons who have been in contact with the child since birth.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

What medical attention was used in case?
 (This space is to be used for a record of all medical attention given to the child from birth to the date of registration.)

FULL NAME OF CHILD (PRINTED)
 SEX
 DATE OF BIRTH
 PLACE OF BIRTH

COUNTY OF
 STATE OF

Division of Health

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the date above stated.

OCCUPATION
 BIRTHPLACE
 AGE AT LAST BIRTHDAY
 COLOR
 RESIDENCE
 NAME
 MAIDEN NAME
 FULL NAME
 MOTHER
 Number of child of this mother previously born, including present birth.

FULL NAME OF CHILD (PRINTED)
 SEX
 DATE OF BIRTH
 PLACE OF BIRTH

COUNTY OF
 STATE OF

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5

RECEIVED JUN 25 1927

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bannock*
City of *Idaho Falls*

Registration District No. *73*
Primary Registration District No. *2100*
(No. *L.D. Hospital* St.)

State File No. *57921*
Local Registrar's No. *77*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Still birth*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

5 - 25 - 1927
(Month) (Day) (Year)

7. AGE

Premature (5 mo)
Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Darryl J. Wood

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Helma Rice

13. BIRTHPLACE OF MOTHER

(State or Country) *Victor Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. Addelman*
(Address) *Idaho Falls*

15. Filed *6/13* 19*27* *(J. J. J. J.)*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 - 25 - 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 25 1927* to *May 25 1927*
that I last saw him alive on *May 27 1927*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Premature birth 5 months fetus

(Duration) yrs. mos. ds. *accidental*
Contributory *Premature Rupture of Amnion*
(Secondary) *5* ds.

(Signed) *[Signature]* M. D.
5/25/27 (Address) *Idaho Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

cremation hospital

DATE OF BURIAL

5/25 1927

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 1 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. 238 703.016.622 St.

Registration District No. 117

State File No.

152865

Hospital

Primary Registration District No. 2196

Local Registrar's No. 3647

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Date of
birth

(Month) (Day)

1927
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn ☐ M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

June 22 1927

Registrar.

Registrar.

UNITED STATES PUBLIC HEALTH SERVICE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 115
Primarily Registration District No. 115

Child's name at birth (Print or type full name without the name of child)
Date of birth (Month, Day, Year)
Sex (Male or Female)
Place of birth (City, State, and Country)
Date of registration (Month, Day, Year)

Child's name at birth (Print or type full name without the name of child)
Date of birth (Month, Day, Year)
Sex (Male or Female)
Place of birth (City, State, and Country)
Date of registration (Month, Day, Year)
MOTHER'S NAME (Print or type full name)
RESIDENCE (Print or type full name)
COLOR (Print or type full name)
BIRTHPLACE (Print or type full name)
OCCUPATION (Print or type full name)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born on (Month, Day, Year) at (City, State, and Country).
Signature of Physician or Midwife
Address
Date of registration (Month, Day, Year)

THIS CERTIFICATE IS TO BE FILED IN THE BUREAU OF VITAL STATISTICS, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, D.C.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1927

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57952

County of ButlerRegistration District No. 117City of SpringdalePrimary Registration District No. 2196Local Registrar's No. 911

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Boy</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
----------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of none6. DATE OF BIRTH (month, day and year) May 3, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<u>1</u>	<u>3</u>	<u>3</u>	<u>1</u>	<u>10</u>

8. OCCUPATION OF DECEASED(a) Trade, profession, or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9. BIRTHPLACE (city or town) Butler, Idaho
(State or country)10. NAME OF FATHER James Schooner11. BIRTHPLACE OF FATHER (city or town) Butler, Ida
(State or Country)12. MAIDEN NAME OF MOTHER Lula Gibson13. BIRTHPLACE OF MOTHER (city or town) Butler, Ida
(State or Country)14. Informant mother
(Address)15. Filed June 15, 1927 Dr. J. C. Patterson
Registrar**MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH May 3, 1927

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 3, 1927, to May 7, 1927that I last saw him alive on May 3, 1927and that death occurred, on the date stated above, at 10 P. m.The CAUSE OF DEATH* was as follows:
StrokeCONTRIBUTORY
(Secondary)(duration) 1 yrs. 1 mos. 1 ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? no(Signed) J. C. Patterson, M. D._____, 19____ (Address) Butler

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Butler, Ida May 3 192720. Undertaker None Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 11 1927

STATE OF IDAHO

County of Idaho

DEPARTMENT OF PUBLIC WELFARE

City of Cottonwood

BUREAU OF VITAL STATISTICS

No. _____ St.

CERTIFICATE OF BIRTH

669-224 025-132

Registration District No. 105 State File No. 153000

(If born in hospital or institution
give name.)

Prim. Registration District No. 2183 Local Registrar's No. 54

FULL NAME OF CHILD Cornelia Foreman (stillbirth)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 24 1927</u> (Month) (Day) (Year)
-----------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 9 (a) Born alive and now living 8

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Frank Foreman</u>	MOTHER FULL MAIDEN NAME <u>Kate J. Albers</u>
--	--

Residence (Usual place of abode) Cottonwood

If nonresident, give place and State _____

Color or race W. Age at last Birthday 40 (Years)

Birthplace Effingham, Ill. (City and State or Country)

Occupation Farming

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at H. A. M.
on the date above stated.

(Signature) Wesley F. Orr M.D.

(Physician or midwife)

Address Cottonwood, Ida.

Filed July 5 1927 W. F. Orr per 9.13

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

OFFICE OF THE REGISTRAR

CERTIFICATE OF BIRTH

155400

Registration District No. _____

Local Registration Office No. _____

NAME OF CHILD

Sex	Age	Height	Weight	Color of hair	Color of eyes	Color of skin
_____	_____	_____	_____	_____	_____	_____

Child's name was used in present ()

Number of child of this mother, including present ()

Child alive at present ()

Child's name	Child's sex	Child's age	Child's height	Child's weight	Child's color of hair	Child's color of eyes	Child's color of skin
_____	_____	_____	_____	_____	_____	_____	_____

Child's name ()

Child's sex ()

Child's age ()

Child's height ()

Child's weight ()

Child's color of hair ()

Child's color of eyes ()

Child's color of skin ()

Child's name ()

Child's sex ()

Child's age ()

Child's height ()

Child's weight ()

Where there was no attending physician or midwife, then the father, grandfather, or another male, who was a witness, shall be one of the persons who shall sign the certificate of the birth of the child.

(Signature)

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Signature of attending physician or midwife _____

Address _____

Signature of attending physician or midwife _____

Address _____

Signature of attending physician or midwife _____

Address _____

Signature of attending physician or midwife _____

Address _____

CERTIFICATE OF DEATH.

57983

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

City of Cottonwood

(No.)

St.

File No. 10

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cornelia Foreman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

June 24 1927
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Foreman

11. BIRTHPLACE OF FATHER

(State or Country)

Effingham, Ill.

12. MAIDEN NAME OF MOTHER

Kate J. Albers

13. BIRTHPLACE OF MOTHER

(State or Country)

Salem, So. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank Foreman
Cottonwood, Ida.

(Address)

15.

Filed

July 5 1927

H. F. Over...

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth
Unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

6/24 1927 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, Ida 6/24 1927

ADDRESS

Frank Foreman Cottonwood, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

619-7141028-296
PLACE OF BIRTH
County of Kootenai
City of Spokane
No. St.
Registration District No. 45 State File No. 153004
(If born in hospital or institution give name.)
Prim. Registration District No. Local Registrar's No. 19
FULL NAME OF CHILD Baby Wark (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child M Twin Triplet or other? and Number in order of birth Legitimate? yes Date of birth May 14 1927
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? Silver nitrate
Number of child of this mother, including present birth 4 (a) Born alive and now living 3
Born alive but now dead 0 Stillborn 1
FATHER FULL MAIDEN NAME MOTHER
FULL NAME Clyde Wark FULL NAME Clara Piolet
Residence (Usual place of abode) Spokane Idaho Residence (Usual place of abode) Spokane
If nonresident, give place and State
Color or race Wh Age at last Birthday 29 Color or race Wh Age at last Birthday 32
(Years) (Years)
Birthplace Harrison Ida Birthplace Maryland
(City and State or Country) (City and State or Country)
Occupation Logger Occupation House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1 P. M. on the date above stated.

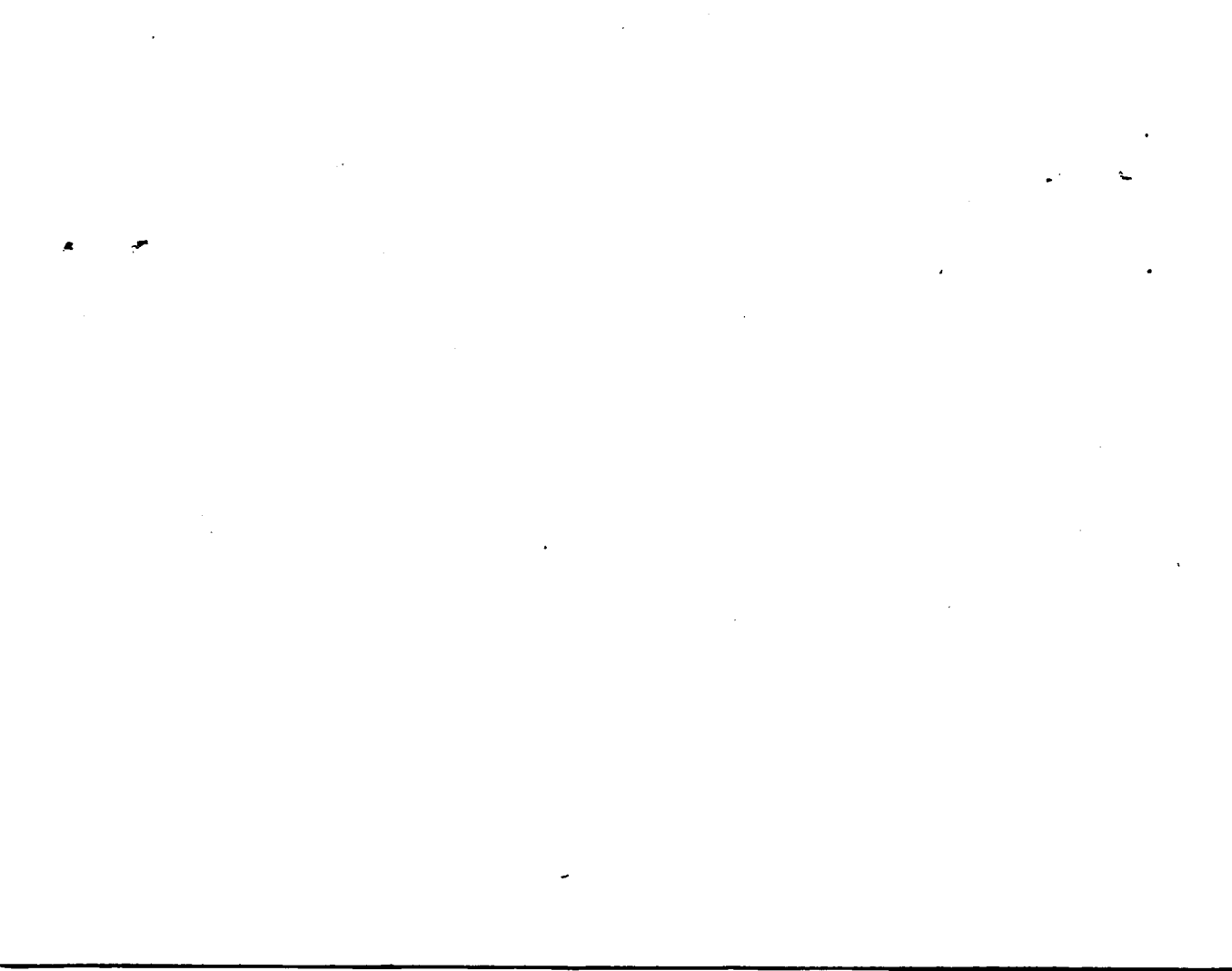
(Signature) U C Spooner

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Phys.
(Physician or midwife)

Address Spokane Idaho

Filed May 15 1927 U C Spooner
Registrar.



RECEIVED JUN 20 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 57986

County of Kootenai

City of Spirit Lake

Registration District No. 45-

Primary Registration District No.

Local Registrar's No. 6

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth (Baby Wark)

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Wh.

5. Single, Married, Widowed,
or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

May 14 1927

7. AGE

Years

Months

Days

If LESS than 1 day,

0

0

0

0

hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Spirit Lake, Ida

10. NAME OF FATHER

Clyde Wark

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Harrison, Ida

12. MAIDEN NAME OF MOTHER

Clara Prozet

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Maryland

14. Informant

(Address)

Mrs Clyde Wark
Spirit Lake, Ida

15.

Filed

May 15, 1927

A C Spooner

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 14 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillbirth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) A C Spooner, M. D.

May 14, 1927 (Address) Spirit Lake, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Spirit Lake, Ida

May 15, 1927

20. Undertaker

Address

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

215-126035-764

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of Nez Perce

CERTIFICATE OF BIRTH

S 153143

City of LapwaiRegistration District No. 128

File No.

No.

St. Caldwell & Henry

Hospital

Primary Registration District No.

Registered No.

FULL NAME OF CHILD Charles Kane

Sex of Child

MaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?yesDate of
BirthMay 26
(Month) (Day)1927
(Year)FULL
NAMEFATHER
John KaneFULL
MAIDEN
NAME

MOTHER

Ellen Fowler

RESIDENCE

Lapwai Idaho

RESIDENCE

Lapwai Idaho

COLOR

Indian 1/4AGE AT LAST
BIRTHDAY47
(Years)

COLOR

Indian 1/4AGE AT LAST
BIRTHDAY37
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 6Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born ✓, at 7:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo O. Keen M.D.
Physician Lapwai Idaho
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

1927

George Guymard M.D.
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS FILED IN THE BIRTH RECORDS OF THE CITY OF NEW YORK, FOR THE YEAR 1914, IN THE DISTRICT OF NEW YORK, IN THE CITY OF NEW YORK, IN THE COUNTY OF NEW YORK, IN THE STATE OF NEW YORK.

CERTIFICATE OF BIRTH
STATE OF NEW YORK

PLACE OF BIRTH

County of

City of

No.

Residence

FULL NAME OF CHILD

Sex of

Color

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Signature

Date of

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Date of

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Date of

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Date of

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

Date of

Birth

Residence

Color

Birthplace

Occupation

Signature

Witness

Registrar

Notary

Signature

Notary

Signature

Notary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. B. 12-13-14 **RECEIVED JUN 27 1927**

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 128

County of Myer

Primary Registration District No. 128

City of Lapwai

(No. Caldwell & Kimberly)

File No. 58040

Registered No. 189-6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Kane.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single.

(Write the word.)

6. DATE OF BIRTH.

May 26 1927
(Month) (Day) (Year)

7. AGE

If LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed May 1927

1927

George Gaimard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

191 May 26 1927

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still Born child,
7 1/2 months baby,
Cause unknown,

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Geo O. Keck M. D.

5/27 1927 (Address) Lapwai Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai Idaho

5/27 1927

20. UNDERTAKER

Family

ADDRESS

Lapwai Ida.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

263-1041035-652
PLACE OF BIRTH

RECEIVED JUL 1 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

153151

County of Nez Perce..

City of Peck, Ida.

No. _____ St. _____ Registration District No. 93 State File No. _____

Hospital _____ Primary Registration District No. 2371 Local Registrar's No. _____

FULL NAME OF CHILD No. name.

(Certificate of no value without full name of child)

Sex of Child <u>Male.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes.</u>	Date of birth <u>April 4th, 1927</u> (Month) (Day) (Year)
------------------------------	---	--------------------------------------	------------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER	MOTHER
FULL NAME <u>Walter Bolon</u>	FULL MAIDEN NAME <u>Florence Westling</u>
RESIDENCE <u>Peck, Idaho.</u>	RESIDENCE <u>Peck, Idaho.</u>
COLOR <u>White,</u>	COLOR <u>White.</u>
AGE AT LAST BIRTHDAY <u>41</u> (Years)	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Wash.</u>	BIRTHPLACE <u>Minn.</u>
OCCUPATION <u>Laborer.</u>	OCCUPATION <u>House wife.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn at 6:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. F. Robertson

Physician

(Physician or midwife)

Address

Orofino, Idaho.

Filled

5/2

192 7

Dan Lyle

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19

RECEIVED JUL 1 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez Perce
City of Peek

Registration District No. 93
Primary Registration District No. 2371
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 58021
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Bolon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH Apr 3 1927
(Month) (Day) (Year)

7. AGE ✓ Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Walter Bolon

11. BIRTHPLACE OF FATHER

(State or Country)

Wash

12. MAIDEN NAME OF MOTHER

Florence Inetta Westling

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Bolon

(Address)

Peek Ida

15.

Filed 4-4-

1927

Dan Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 3 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Fairley M. D.

4-4-1927 (Address) Archie

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Newston Ida

DATE OF BURIAL

4-5-1927

20. UNDERTAKER

Brower Wame

ADDRESS

Newston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

551-219-
PLACE OF BIRTH RECEIVED JUL 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 153178

No. _____ St. _____ Registration District No. 26 State File No. _____
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 84

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth 6-19 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Richard D. Evans.</u>	FULL MAIDEN NAME	<u>Rocky Jones.</u>
RESIDENCE	<u>Malad Ida</u>	RESIDENCE	<u>Malad Ida</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Malad Ida</u>	BIRTHPLACE	<u>Malad Ida</u>
OCCUPATION	<u>Farmer.</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive ☒ Stillborn ☐ } at 11:10 a a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) _____

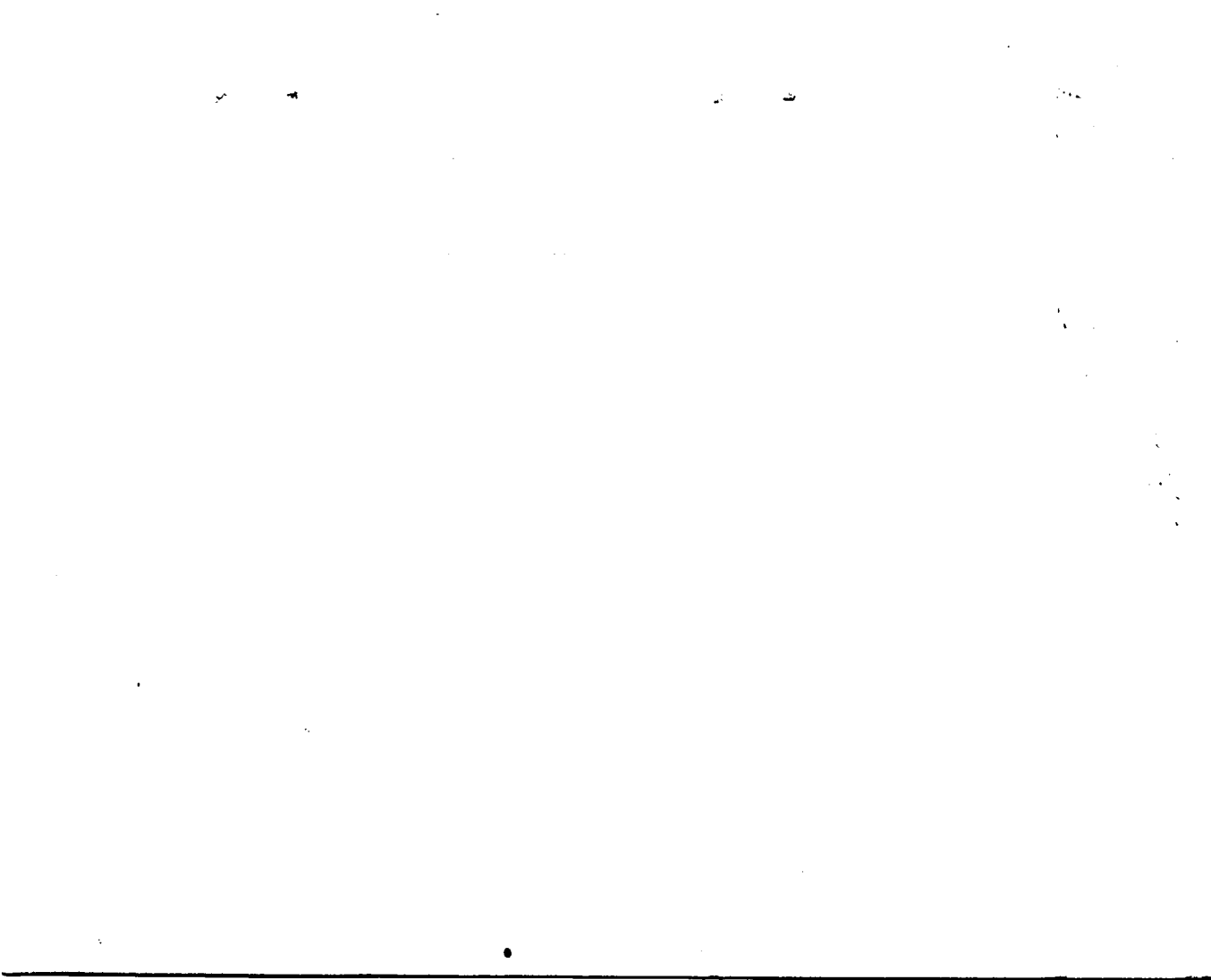
(Physician or midwife)

Address _____

Filed 6/30 1927

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 5 1927 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1

County of *Sevier*Primary Registration District No. *2069*File No. *58065*City of *Martinsburg*

(No. _____ St.)

Registered No. *123*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female* *white* *single*
(Write the word.)

6. DATE OF BIRTH

6 - 19 1927
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Malden Ids

10. NAME OF FATHER

Richard J. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Malden Ids

12. MAIDEN NAME OF MOTHER

Rachel Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Malden Ids

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard J. Evans

(Address)

Malden Ids

15.

Filed *6/30* 19 *27*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 - 19 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

attended the birth 19

that I last saw h. _____ alive on _____ 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Impetigo...
Full term

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. M. Jones* M. D.*6/19 1927* (Address) *Malden Ids*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Malden Ids

DATE OF BURIAL

6/20 1927

20. UNDERTAKER

Guy Bureau

ADDRESS

Malden Ids

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Winn Falls
City of Castelford

CERTIFICATE OF BIRTH

No. 235217.042-296 St.

Registration District No. 39 State File No. 153232

(If born in hospital or institution
give name.)

Prim. Registration District No. 2.087 Local Registrar's No.

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>6-17</u> (Month) (Day) (Year) <u>1927</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 1

Born alive but now dead 3 Stillborn

FATHER
FULL NAME D. Blew

MOTHER
FULL MAIDEN NAME Olivia Brown

Residence (Usual place of abode) Castelford

Residence (Usual place of abode) Castelford

If nonresident, give place and State

If nonresident, give place and State

Color or race W Age at last Birthday 43
(Years)

Color or race W Age at last Birthday 36
(Years)

Birthplace Mo
(City and State or Country)

Birthplace Mo
(City and State or Country)

Occupation Farm laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:30 a.m.
on the date above stated.

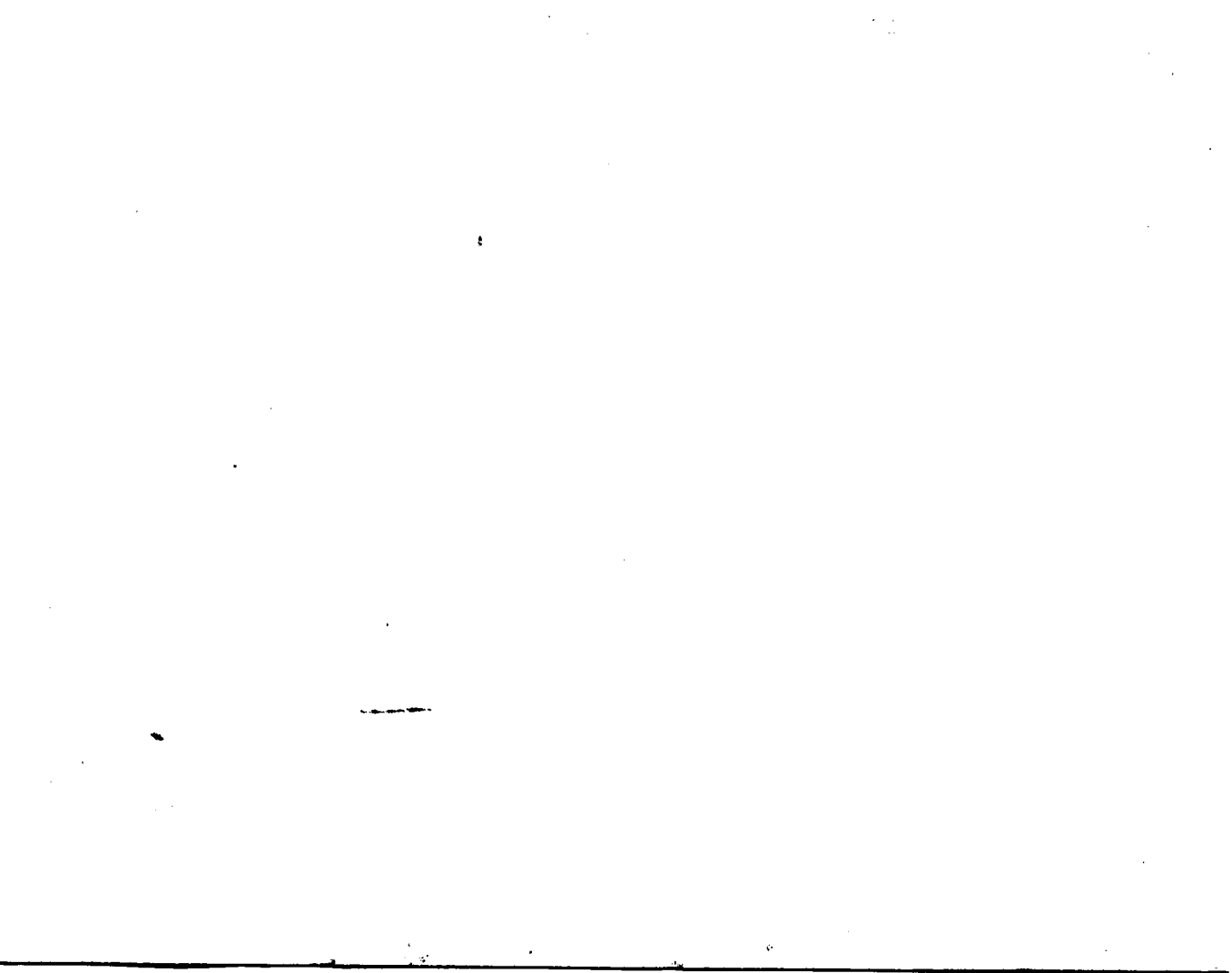
(Signature) Ad. McElroy

(Physician or midwife)

Address Guthrie, Ida

Filed 6-30 1927 J. H. Murphy
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

269-225,044-279

PLACE OF BIRTH

County of Washington

City of Weiser

No. _____ St. _____

(If born in hospital or institution
give name.)

RECEIVED JUN 16 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 153283

Registration District No. 56 State File No. _____

Prim. Registration District No. 110 Local Registrar's No. 26

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>3 - 25 - 1927</u> (Month) (Day) (Year)
----------------------------	---	-------	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Felix C. Hogiel

Residence (Usual place of abode) Weiser

If nonresident, give place and State _____

Color or race White Age at last Birthday 26 (Years)

Birthplace Little Falls Minn.
(City and State or Country)

Occupation Forest Service

MOTHER
FULL MAIDEN NAME Bernice Spring

Residence (Usual place of abode) Weiser Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 25 (Years)

Birthplace Michigan
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 3:30 p. M.
on the date above stated.

(Signature) Ernest C. Finney

(Physician or midwife)

Address _____

Filed May 18 - 1927 W. R. Hamilton

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

Registration District No. _____ State Title No. _____

It is not known if "S. aureus" has any other medical uses.

1. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)

Was the hypodermic used to prevent Opium addiction?

1-1-1970

STANTON

JUL
 MEDIAN
 1944

SECRET

3. 4. 7. 8.

(made to order form) continued

(Shots to air last) searching

(S) (U.S. State Dept.)

Overnight

City and State of Connecticut

SECRET

INVESTIGATE BY ATTENDING PHYSICIAN OR SURGEON

I hereby certify that I attended the birth of this child, who was born on 11/11/1941.

(continued)

(41) wife, 20-25, 1949

There were no attending physicians at the time of the accident. The father, however, should make this return. A physician would be one that neither provider nor patient would be able to identify as having been involved in the accident.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **58103**

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH.**

County of Washington Registration District No. Y6
City of Wenatchee Primary Registration District No. 2112
(No. _____ St.

if death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Booby Roedel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE WHP	5. SINGLE, MARRIED, WID- OWED OR DIVORCED. single (Write the word.)
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6. DATE OF BIRTH. March 25 1977
(Month) (Day) (Year)

7. AGE 21 Wilson
Yrs. Mos. ds.
IF LESS than 1 day
how many.....hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

19. NAME OF FATHER 76. Kozul

11. BIRTHPLACE
OF FATHER
(State or Country) *Missouri*

12. MAIDEN NAME OF MOTHER *Bernice Sprint*

13. BIRTHPLACE
OF MOTHER
(State or Country) *Michigan*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. J. Cozco
(Address) Waverly Inn

15. *March 26^A 1927* *G. R. Hamilton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended, deceased from
 _____ 191 Birth _____ 191 _____
 that I last saw h _____ alive on _____ 191 _____

and that death occurred on the date stated above, atM
The CAUSE OF DEATH* was as follows:

**Contributory
(Secondary)**

(Duration) yrs. ¹ mos. ds.
(Signed) Ernesto Fernandez M.D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	191

20. UNDERTAKER	ADDRESS
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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S B

County of Ada RECEIVED AUG 6 1927

City of Boise CERTIFICATE OF BIRTH 153368

No. 231-218-001-843 St. Registration District No. 2 State File No. 1004

Hospital Alphonsus Primary Registration District No. 1004 Local Registrar's No. 268

FULL NAME OF CHILD Infant Starn
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth Legiti- mate? Yes Date of birth 7 18 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Clifford Starn</u>	<u>Boise - Idaho.</u>	<u>Hazel Hutchinson</u>	<u>Boise</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Boise, Idaho.</u>	OCCUPATION <u>Rail road freight agt.</u>	BIRTHPLACE <u>Kansas</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

G. Emmett Parth
Physician
(Physician or midwife)

Address

Boise, Idaho

Filed

7-18-1927

Registrar.

Registrar.

(ESTABLISHED 1911)

CONFIDENTIAL - Do not release to the public

Flintbury Registration District No. 1, Local Residents No.

01110 30-5 MAY 1974

(All fields in names that model no value or no condition)

TO BE RETURNED ONLY IN CASE OF CANCELLATION

What individualized action was used in 1979?

David Lawrence Goldberg, Jewish was victim and he tried to commit

JJUR
 2014.04

將軍姓丁A

JUL 1974
 WBC 3A 14
 2188

ЯЗНТОМ

SECRET

1221 1A 10A
NOT AT LAST
COLOR

REJCT

TRAJ TA 30A
COUNTRY

SCIENTIFIC

5041

020494

4017A9U290

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

1. I am now living with my mother and father in the city of New York.

There were no attending physician at the time of the shooting. The father, however, was present. The father, however, was present. The father, however, was present.

(4) (b) (i) (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z) (AA) (AB) (AC) (AD) (AE) (AF) (AG) (AH) (AI) (AJ) (AK) (AL) (AM) (AN) (AO) (AP) (AQ) (AR) (AS) (AT) (AU) (AV) (AW) (AX) (AY) (AZ) (BA) (BB) (BC) (BD) (BE) (BF) (BG) (BH) (BI) (BJ) (BK) (BL) (BM) (BN) (BO) (BP) (BQ) (BR) (BS) (BT) (BU) (BV) (BW) (BX) (BY) (BZ) (CA) (CB) (CC) (CD) (CE) (CF) (CG) (CH) (CI) (CJ) (CK) (CL) (CM) (CN) (CO) (CP) (CQ) (CR) (CS) (CT) (CU) (CV) (CW) (CX) (CY) (CZ) (DA) (DB) (DC) (DD) (DE) (DF) (DG) (DH) (DI) (DJ) (DK) (DL) (DM) (DN) (DO) (DP) (DQ) (DR) (DS) (DT) (DU) (DV) (DW) (DX) (DY) (DZ) (EA) (EB) (EC) (ED) (EE) (EF) (EG) (EH) (EI) (EJ) (EK) (EL) (EM) (EN) (EO) (EP) (EQ) (ER) (ES) (ET) (EU) (EV) (EW) (EX) (EY) (EZ) (FA) (FB) (FC) (FD) (FE) (FF) (FG) (FH) (FI) (FJ) (FK) (FL) (FM) (FN) (FO) (FP) (FQ) (FR) (FS) (FT) (FU) (FV) (FW) (FX) (FY) (FZ) (GA) (GB) (GC) (GD) (GE) (GF) (GG) (GH) (GI) (GJ) (GK) (GL) (GM) (GN) (GO) (GP) (GQ) (GR) (GS) (GT) (GU) (GV) (GW) (GX) (GY) (GZ) (HA) (HB) (HC) (HD) (HE) (HF) (HG) (HH) (HI) (HJ) (HK) (HL) (HM) (HN) (HO) (HP) (HQ) (HR) (HS) (HT) (HU) (HV) (HW) (HX) (HY) (HZ) (IA) (IB) (IC) (ID) (IE) (IF) (IG) (IH) (II) (IJ) (IK) (IL) (IM) (IN) (IO) (IP) (IQ) (IR) (IS) (IT) (IU) (IV) (IW) (IX) (IY) (IZ) (JA) (JB) (JC) (JD) (JE) (JF) (JG) (JH) (JI) (JJ) (JK) (JL) (JM) (JN) (JO) (JP) (JQ) (JR) (JS) (JT) (JU) (JV) (JW) (JX) (JY) (JZ) (KA) (KB) (KC) (KD) (KE) (KF) (KG) (KH) (KI) (KJ) (KK) (KL) (KM) (KN) (KO) (KP) (KQ) (KR) (KS) (KT) (KU) (KV) (KW) (KX) (KY) (KZ) (LA) (LB) (LC) (LD) (LE) (LF) (LG) (LH) (LI) (LJ) (LK) (LL) (LM) (LN) (LO) (LP) (LQ) (LR) (LS) (LT) (LU) (LV) (LW) (LX) (LY) (LZ) (MA) (MB) (MC) (MD) (ME) (MF) (MG) (MH) (MI) (MJ) (MK) (ML) (MM) (MN) (MO) (MP) (MQ) (MR) (MS) (MT) (MU) (MV) (MW) (MX) (MY) (MZ) (NA) (NB) (NC) (ND) (NE) (NF) (NG) (NH) (NI) (NJ) (NK) (NL) (NM) (NN) (NO) (NP) (NQ) (NR) (NS) (NT) (NU) (NV) (NW) (NX) (NY) (NZ) (OA) (OB) (OC) (OD) (OE) (OF) (OG) (OH) (OI) (OJ) (OK) (OL) (OM) (ON) (OO) (OP) (OQ) (OR) (OS) (OT) (OU) (OV) (OW) (OX) (OY) (OZ) (PA) (PB) (PC) (PD) (PE) (PF) (PG) (PH) (PI) (PJ) (PK) (PL) (PM) (PN) (PO) (PP) (PQ) (PR) (PS) (PT) (PU) (PV) (PW) (PX) (PY) (PZ) (QA) (QB) (QC) (QD) (QE) (QF) (QG) (QH) (QI) (QJ) (QK) (QL) (QM) (QN) (QO) (QP) (QQ) (QR) (QS) (QT) (QU) (QV) (QW) (QX) (QY) (QZ) (RA) (RB) (RC) (RD) (RE) (RF) (RG) (RH) (RI) (RJ) (RK) (RL) (RM) (RN) (RO) (RP) (RQ) (RR) (RS) (RT) (RU) (RV) (RW) (RX) (RY) (RZ) (SA) (SB) (SC) (SD) (SE) (SF) (SG) (SH) (SI) (SJ) (SK) (SL) (SM) (SN) (SO) (SP) (SQ) (SR) (SS) (ST) (SU) (SV) (SW) (SX) (SY) (SZ) (TA) (TB) (TC) (TD) (TE) (TF) (TG) (TH) (TI) (TJ) (TK) (TL) (TM) (TN) (TO) (TP) (TQ) (TR) (TS) (TT) (TU) (TV) (TW) (TX) (TY) (TZ) (UA) (UB) (UC) (UD) (UE) (UF) (UG) (UH) (UI) (UJ) (UK) (UL) (UM) (UN) (UO) (UP) (UQ) (UR) (US) (UT) (UU) (UV) (UW) (UX) (UY) (UZ) (VA) (VB) (VC) (VD) (VE) (VF) (VG) (VH) (VI) (VJ) (VK) (VL) (VM) (VN) (VO) (VP) (VQ) (VR) (VS) (VT) (VU) (VV) (VW) (VX) (VY) (VZ) (WA) (WB) (WC) (WD) (WE) (WF) (WG) (WH) (WI) (WJ) (WK) (WL) (WM) (WN) (WO) (WP) (WQ) (WR) (WS) (WT) (WU) (WV) (WW) (WX) (WY) (WZ) (XA) (XB) (XC) (XD) (XE) (XF) (XG) (XH) (XI) (XJ) (XK) (XL) (XM) (XN) (XO) (XP) (XQ) (XR) (XS) (XT) (XU) (XV) (XW) (XX) (XY) (XZ) (YA) (YB) (YC) (YD) (YE) (YF) (YG) (YH) (YI) (YJ) (YK) (YL) (YM) (YN) (YO) (YP) (YQ) (YR) (YS) (YT) (YU) (YV) (YW) (YX) (YZ) (ZA) (ZB) (ZC) (ZD) (ZE) (ZF) (ZG) (ZH) (ZI) (ZJ) (ZK) (ZL) (ZM) (ZN) (ZO) (ZP) (ZQ) (ZR) (ZS) (ZT) (ZU) (ZV) (ZW) (ZX) (ZY) (ZZ)

2596 DA

7. **STANDARD**

RECEIVED AUG 6 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58138

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 152

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Starn

(a) Residence. No. 912 McHenry St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

July 18-1927

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Boise Idaho

10. NAME OF FATHER

Clifford Starn

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Boise Idaho

12. MAIDEN NAME OF MOTHER

Mapel Hutchinson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Kansas

14. Informant

Clifford Starn

(Address)

912 McHenry St. Boise Id.

15. Filed

7-20-1927

Paula McDonald

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7

18

1927

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-18, 1927, to 7-18, 1927

that I last saw her alive on 7-18, 1927

and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Still born

5th month

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. Emmett Raitt, M. D.

7-19, 1927 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery

July 19 1927

20. Undertaker

Address

Summers & Tribe

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

691-1261006-815
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Blackfoot

RECEIVED AUG 13 1927

CERTIFICATE OF BIRTH 153561

No. Gibson St. 121 Registration District No. 121 State File No. 153561
Hospital 2194 Primary Registration District No. 2194 Local Registrar's No. 234
FULL NAME OF CHILD Joseph Frasure

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>July 26 1927</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Eligh Frasure
RESIDENCE Blackfoot, Idaho # 5
COLOR White AGE AT LAST BIRTHDAY 35
(Years)
BIRTHPLACE Ky.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Tamey Hansen
RESIDENCE Blackfoot, Idaho # 5
COLOR White AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Ky.
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Blackfoot Idaho M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. W. Mitchell

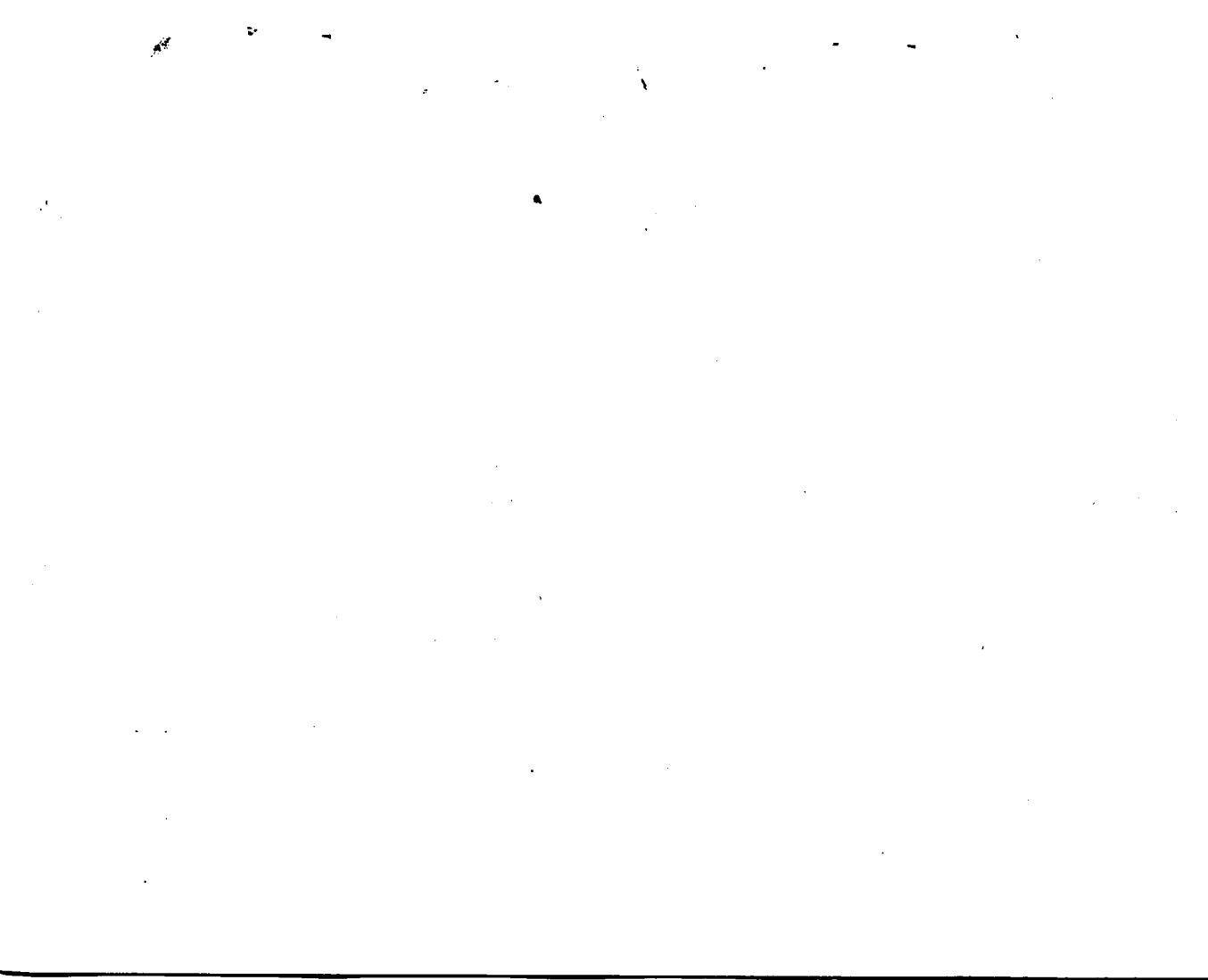
(Physician or midwife)

Address Blackfoot, Idaho

Filed Aug 10 1927 Mrs. C. E. Vantine

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 12 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 58200

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 112

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph H. Hall

(a) Residence. No. 111 Hall Reservado St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)

10 NAME OF FATHER Eli H. Hall

11 BIRTHPLACE OF FATHER (city or town) Ky
(State or country)

12 MAIDEN NAME OF MOTHER Jamieson

13 BIRTHPLACE OF MOTHER (city or town) Ky
(State or country)

14 Informant E. J. Prasad
(Address) 111 Hall St. E.

15 Filed July 26 1927 Mr. Walter S. Cature
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to July 27, 1927, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Boischo
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Compromised airt.
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. W. Mitchell M. D.
July 26, 1927 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Monelwood Cem. Date of Burial 19

20. Undertaker E. H. Prasad Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

168-228016-855

PLACE OF BIRTH

RECEIVED

JUL 25 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Golden Valley

CERTIFICATE OF BIRTH | 53671

No. St. Registration District No. 117 State File No.

Hospital Primary Registration District No. 2196 Local Registrar's No. 3653

FULL NAME OF CHILD Baby Johnstone

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other?	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>6/28/</u> <u>1927</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? Ag. N. O. 3

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Nicholas Johnstone

RESIDENCE Golden Valley

COLOR White AGE AT LAST BIRTHDAY 42 (Years)

BIRTHPLACE Kansas

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Carrie Henry

RESIDENCE Golden Valley

COLOR White AGE AT LAST BIRTHDAY 37 (Years)

BIRTHPLACE Kansas

OCCUPATION Mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Golden Valley Idaho on the date above stated. 2:30 A. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

M.D.
(Physician or midwife)

Address Burley, Idaho.

Filed July 5 1927 R. J. C. Patten

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

296-115-216-995
PLACE OF RECEIVED JUL 25 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 153672

County of Cassia
City of Burley, Ida.

No. _____ St. _____ Registration District No. 117 State File No. _____

Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 3654

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Boy Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth June 15 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol sol.

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Les Nathan Brown
RESIDENCE Paul, Ida.

COLOR White AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE Henry, Wyo.

OCCUPATION laborer

MOTHER
FULL MAIDEN NAME Amber Winn
RESIDENCE Paul, Ida.

COLOR White AGE AT LAST BIRTHDAY 24
(Years)

BIRTHPLACE Parowan, Utah.

OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive ☒ Stillborn ☐ at 11:20 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. H. Cooper M.D.

Physician and Surgeon
(Physician or midwife)

Address Burley, Ida.

Filed July 5, 1927 Dr. J. C. Patterson

Registrar.

Registrar.

18

DEPARTMENT OF JUSTICE
BUREAU OF PRISON INVESTIGATION
STATE OF IDAHO

23615

St. Registration District No. 2145 File No. 2145

Primary Registration District No. 1, Ward 1, City of Chicago, Illinois

UNITED STATES OF AMERICA

(Certificate of no value without full name of child)

**Highland
Festivals**

Noted.

at 2
10/1/19
10/1/19

to 208
b1(2)

(To be answered only in event of joint hearing)

It has been our custom to publish the

Number of child of this mother now living including present birth

Number of child deaths, including breast-feeding

MOTHER

RENTA 9

1103
3 MAY 61

NAME
DIVISION
UNIT

1945年10月1日

COLORED

YACHTS
AGE 30 AT 17

COPIES

(1700)

SECRET

84-1117

И.О. ТАМБЛЮК

COPIES

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hardly recall that I attended the birth of this child, who was (born) at

10-10-68

When there was no attending physician at midnight, the father, homebound, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(2180416)

Following to observe

အမှတ် ၁၆

Refugees

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

266-219-016-853
PLACE OF BIRTH

RECEIVED JUL 15 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burton

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 119 State File No. 153673

Hospital At home Primary Registration District No. 2198 Local Registrar's No. _____

FULL NAME OF CHILD Isabelle Boothe

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? - and { Number in order of birth _____ } Legitimate? yes Date of birth May 19 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER		MOTHER	
FULL NAME	<u>Hubert R Boothe</u>	FULL MAIDEN NAME	<u>Maggie Henderson</u>
RESIDENCE	<u>Burton Idaho</u>	RESIDENCE	<u>Burton Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>42</u> (Years)	AGE AT LAST BIRTHDAY	<u>44</u> (Years)
BIRTHPLACE	<u>Wellsville Utah</u>	BIRTHPLACE	<u>Clarkston Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:30 A. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) C. H. Sauer

(Physician or midwife)

Address Malta Idaho

Filed July 10 1927

Registrar.

Registrar.

THIS IS TO CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN AT THE PLACE AND DATE INDICATED HEREON AND THAT THE SIGNATURE OF THE ATTENDING PHYSICIAN IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD.

Registrar

193

If a name other than a supplemental report
 is given other evidence of the child's birth
 shall be made a return A statement
 or otherwise then the father household
 of the date above stated.

I hereby certify that I attended the birth of this child, who was born at _____ at _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION		BIRTHPLACE		AGE AT LAST BIRTHDAY		COLOR	
OCCUPATION		BIRTHPLACE		AGE AT LAST BIRTHDAY		COLOR	

NAME		FATHER		MOTHER	
NAME		FATHER		MOTHER	

Number of child of this mother, including present birth		Number of child of this mother, including present birth	
Number of child of this mother, including present birth		Number of child of this mother, including present birth	

FULL NAME OF CHILD		Primary Registration District No.		Local Registration District No.	
FULL NAME OF CHILD		Primary Registration District No.		Local Registration District No.	

CERTIFICATE OF BIRTH		DEPARTMENT OF PUBLIC HEALTH		IDAHO	
CERTIFICATE OF BIRTH		DEPARTMENT OF PUBLIC HEALTH		IDAHO	

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

312-105-018-251
PLACE OF BIRTH

County of Clearwater
City of Cavendish, Ida.
No. Orofino St.

Orofino
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

153681

Registration District No. 90 State File No. 4

Prim. Registration District No. 2168 Local Registrar's No. 4

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth (Month) <u>July</u> (Day) <u>5th</u> (Year) <u>1927</u>
-----------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol

Number of child of this mother, including present birth 2 (a) Born alive and now living I

Born alive but now dead 10 Stillborn I

FATHER
FULL NAME Roy LeBaron

Residence (Usual place of abode) Cavendish, Ida.

If nonresident, give place and State _____

Color or race White Age at last Birthday 37 (Years)

Birthplace Kansas
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Mary Keane

Residence (Usual place of abode) Cavendish, Ida.

If nonresident, give place and State _____

Color or race White Age at last Birthday 39 (Years)

Birthplace Wis.
(City and State or Country)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive { at 6.30 P. M.
on the date above stated.

(Signature) J. M. Gailly

Physician
(Physician or midwife)

Address Orofino, Idaho

Filed Aug. 1st 1927 J. M. Gailly
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

5.187a 1714. In 1952, it failed to produce any new seeds.

"Where there was no attending physician or midwife, then the father, household head, should make the return. A stillborn child is one that neither breathes nor shows other signs of life after birth."

is also above stated.

(21844)

It is hereby verified that I attended the birth of this child, who was born at Clinton, N. Y.

CONFIDENTIALITY OF ATTENDING PHYSICIAN'S RECORDS

(SECRET) TO DIRECTOR (100-441114)

Copy of this letter to be sent to the following:

12 non-individuals live here and state has only 913 inhabitants 12

~~CONFIDENTIAL~~

NOTES: 101 102 103 104

RENTAT

has been left open.

2

7/19/68 - Specific was used to prevent Ophiocordyceps

100-443887-100

THE MUSE

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-443887-100

(U) [REDACTED]

Robertson, D.

10-10-68

10-10-68

NO. 101-1037

FILE NO 30-12

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

S

County of Yuma

City of Emmett

No. 253-225-023636 St.

Registration District No. 6

State File No.

Hospital

Primary Registration District No.

Local Registrar's No.

CERTIFICATE OF BIRTH **153718**

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

6/25

1927

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0

FULL
NAME

FATHER

Victor Kelley

RESIDENCE

Emmett Ida

COLOR

white

AGE AT LAST
BIRTHDAY

20
(Years)

BIRTHPLACE

Emmett

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Core Alice Flowers

RESIDENCE

Emmett

COLOR

white

AGE AT LAST
BIRTHDAY

17
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4 30 a M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

C. D. Cummings

(Physician or midwife)

Address

Emmett

Filed

8/8

1927

J. H. Reynolds
Registrar.



CONFIDENTIAL

Page 1

Subject: [REDACTED]

Source: [REDACTED]

Reference: [REDACTED]

Remarks: [REDACTED]

Date: [REDACTED]

Signature: [REDACTED]

Initials: [REDACTED]

MP

9/19/27
WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

818-118-024-366
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

153736

RECEIVED

CERTIFICATE OF BIRTH

County of Gooding
City of Gooding
No. St. Registration District No. State File No.
Hospital Gooding Co Primary Registration District No. 24 Local Registrar's No. 191
FULL NAME OF CHILD Bayes

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth Legitimate? yes Date of birth July 18 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

FATHER		MOTHER	
FULL NAME	<u>Robert E. Bayes</u>	FULL MAIDEN NAME	<u>Reba Toohay</u>
RESIDENCE	<u>Gooding</u>	RESIDENCE	<u>Gooding, Id.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>30</u> (Years)
BIRTHPLACE	<u>Wis.</u>	BIRTHPLACE	<u>Mass.</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 11 9 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) J. H. Crummett
(Physician or midwife)

Address Gooding, Id.

Filed 7/31 1927 J. H. Crummett Registrar.

Registrar.

Registrar.

...the ... of ...

44-38861-1000

ONAGI TO BUREAU
THAT NEW PLANS TO DISMANTLE
SUBMERSIBLE LAIR TO BUREAU
HTON TO BUREAU (P)

HP 1000 (10/15/77)

Registration District No. _____ State File No. _____

Primary Registration Station No. _____ Local Highway No. _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

(Certification of no value without full name of child)

10-225
6111

1890-1891

Another of kind of this species now living, including present form.

Number of field in this column, including present work.

2407
MAY 1964

DISSENT

人非草木
孰能无情

只認得(唐詩)

SECRET

COLON

AG AT LAST
YACHTING

0304

BIRTHPLACE

2020年10月10日

OCCUPATION

अवध प्रपत्र २३०

CERTIFICATE OF ATTENDING PHYSICIAN OR NURSE

1 person certify that I attended the birth of this child, who was born at

on the date above stated.

* When there was no attending physician
at midville then the doctor, Dr. J. H. H. H.
should make the return. A stillborn
child is one that has been delivered but
shows some evidence of life after birth.

(07054521E)

reference to page 14)

42371

Ref: 100-361101

●●●

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH RECEIVED AUG 10 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Gooding
City of "

Registration District No. 24
Primary Registration District No. "
(No. " St.)

State File No. 58246
Local Registrar's No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word)

6. DATE OF BIRTH

July 18 ' 27
(Month) (Day) (Year)

7. AGE

Fullborn
IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Gooding Idaho

10. NAME OF FATHER

Robert Hayes

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Helen Tracy

13. BIRTHPLACE OF MOTHER

(State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Hayes

(Address) Gooding Idaho

15.

Filed 7/31- 19 27 H. C. Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18 19 27
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fullborn - Mother a decay - Cancer section

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Conway M. D.

7/31 19 27 (Address) Gooding

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Gooding Idaho 7/19- 19 27

20. UNDERTAKER

H. C. Conway Gooding

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

243-112-025-796
PLACE OF BIRTH

County of Idaho

City of Ketchikan

No. _____ St. _____

(If born in hospital or institution
give name.)

Registration District No. 106 State File No. 153758

Prim. Registration District No. 2184 Local Registrar's No. 134

FULL NAME OF CHILD Sullivan

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 12 1927</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 4

FATHER FULL NAME <u>Felix Ramville</u>	MOTHER FULL MAIDEN NAME <u>Georgia Grover</u>
---	--

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 38 (Years)

Birthplace Walla Walla (City and State or Country)

Occupation Farmer

Color or race white Age at last Birthday 24 (Years)

Birthplace Wallace (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12¹⁰ a. M.
on the date above stated.

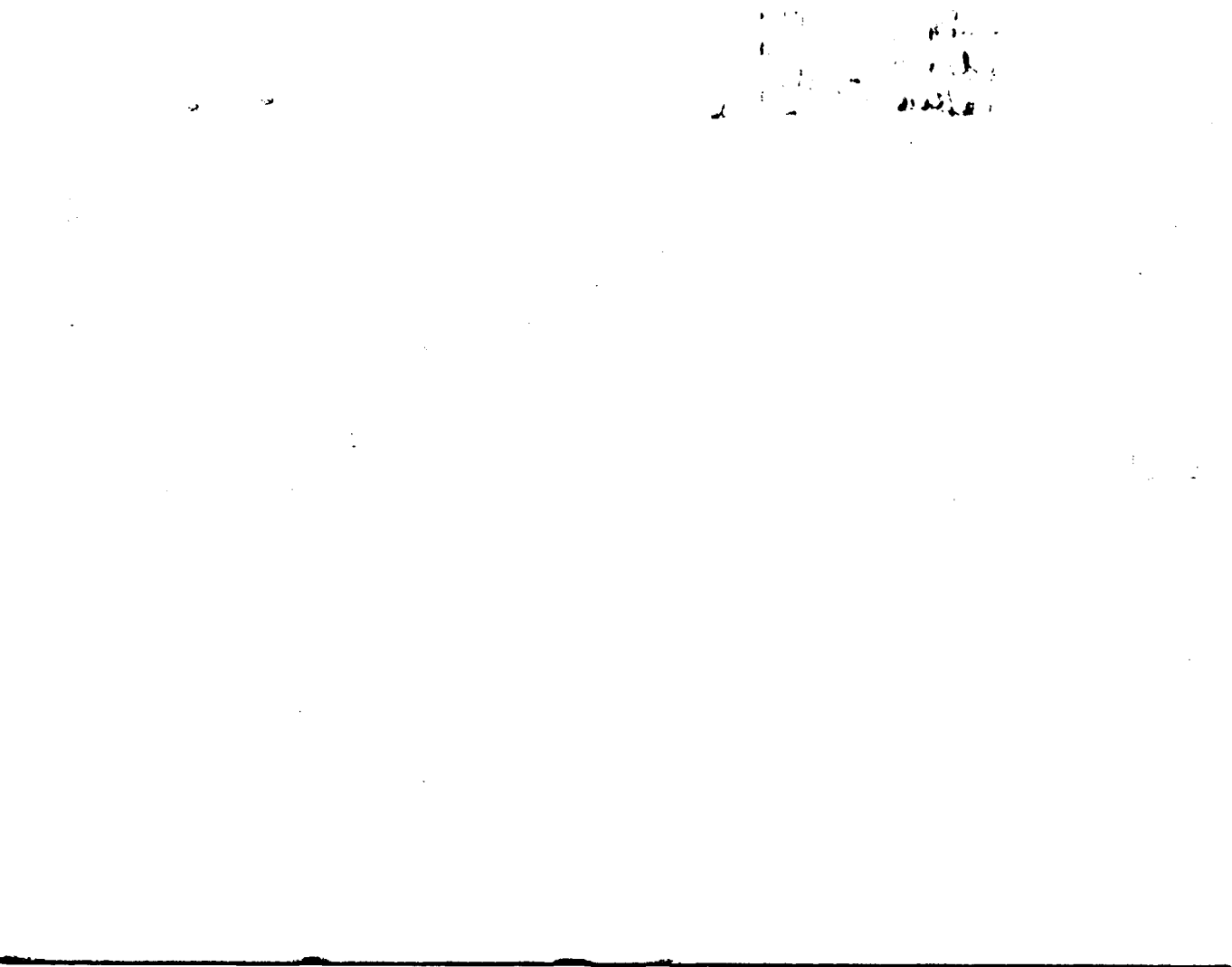
(Signature) J. M. Verbeekmaas

(Physician or midwife)

Address Kootenai Idaho

Filed Aug 1 1927 J. M. Verbeekmaas
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
County of Idaho
City of Kassia
Registration District No. 106
Primary Registration District No. 2184

DO NOT WRITE IN THIS SPACE

State File No. 58300

Local Registrar's No. 238

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shelburne 6 mo Jones

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) July 12 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Shelburne

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) near Kassia
(State or country)

10. NAME OF FATHER Felix Rasmussen

11. BIRTHPLACE OF FATHER (city or town) Walla Walla
(State or Country)

12. MAIDEN NAME OF MOTHER Gertie Jones

13. BIRTHPLACE OF MOTHER (city or town) Walla Walla
(State or Country)

14. Informant Felix Rasmussen
(Address) Kassia - Idaho

15. Filed July 13, 1927 J. M. Vukobratovich
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

6 1/2 mo. Jones

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. M. Vukobratovich M. D.

July 13, 1927 (Address) Kassia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kassia Cemetery

July 13 1927

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

613-101-024-225
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

153822

84

County of Latah

City of Moscow

No. 845E-28

REC'D AUG 10 1927

Registration District No. 61

File No.

Hospital

Primary Registration District No. 1011

Registered No.

FULL NAME OF CHILD

John Oliver Walker

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>7/1</u> 192 <u>7</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? Rebayer Nitrate

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Hubert E. Walker
RESIDENCE Moscow Ida.
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE N. Carolina
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Margaret Skeen
RESIDENCE Moscow Ida.
COLOR White AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 P M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Harry Engholm
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Moscow Ida.
Filed Aug 4 1927 W. H. Caruthers
Registrar.

PLATE OF BIRTH

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 1405
 Registration District No. 1405
 Registered No. 1405

TRUE NAME OF CHILD

Field to report that would be subject to classification

[illegible]

What alternative solution was used in case?

Number of child of this mother including cross of birth

Number of child of this mother now living

MOTHER

FAIRER

RESIDENT
NAME
WALDEN
FULL

MOTHER

5-11-68
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DATE OF BIRTH: 1940-01-01

TEAJ TA'EDA
YANTHIA

10-10-68

100-443887-100

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

M sa saw edw .blind piff lu droid nbs kshastta l and rthre vferd i
 (09.03.19) to 7118 reutl baretz evods erst est ge

1. The following information is being furnished to you for your information and is not to be used for any other purpose. A copy of this information is being furnished to the appropriate authorities for their consideration.

Give us the right to a dignified report.

1951

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give full address of place where death occurred, and name of person called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. St.)

2. FULL NAME John Owen Walker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 58327

Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Child

(Write the word.)

6. DATE OF BIRTH.

July 1 1927
(Month) (Day) (Year)

7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Moscow, Idaho

10. NAME OF FATHER

Hubert E. Walker

11. BIRTHPLACE OF FATHER

(State or Country) N. Car.

12. MAIDEN NAME OF MOTHER

Margaret S. Skeen

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hubert E. Walker

(Address) Moscow, Ida.

15.

Filed July 2 1927

W. H. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw him alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Born July 1, 1927
stillborn.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John E. Emmons M. D.

7/1 1927 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow Ida.

DATE OF BURIAL

July 9 1927

20. UNDERTAKER

F. R. Short

ADDRESS

Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

855-114-029-389
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Troy Ida

No. _____ St. _____ Registration District No. 64 State File No. 153837

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD (Infant) Kendrick

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>7-14</u> 192 <u>7</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? 20% Argol sol

Number of child of this mother, including present birth 7th Number of child of this mother now living, including present birth 6

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Thomas Kendrick</u>	<u>Troy, Idaho</u>	<u>Bessie Tyrrell</u>	<u>Troy, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Washington</u>		BIRTHPLACE <u>Arkansas</u>	
OCCUPATION <u>Mill laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 5 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Lucy M. Pickard July 31, 1927
Registrar.

(Signature) A. H. Meyer

(Physician or midwife)

Address Troy, Idaho

Filed July 31, 1927

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____

Primary Registration District No. _____ Local Registrar's No. _____

(Certificate of no value without full name of child)

Sex of child _____ Date of birth _____
 (To be entered only in event of placental birth)

What pathological condition was noted in report _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

MOTHER

FATHER

FULL NAME
MOTHER

FULL NAME
FATHER

RESIDENCE

RESIDENCE

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

COLOR

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

on the date above stated.

When there was no attending physician or midwife, then the father, householder, etc. should make this return. A stillborn child is one that neither previves nor shows other evidence of life after birth. Give names added, was a pathological report _____

(Signature)

(Physician or midwife)

Address

Filed

Registered

NOTED: This certificate is not valid unless the child is born in Idaho and the mother is a resident of Idaho at the time of birth. It is not valid if the child is born in Idaho and the mother is a resident of another state at the time of birth. It is not valid if the child is born in another state and the mother is a resident of Idaho at the time of birth. It is not valid if the child is born in another state and the mother is a resident of another state at the time of birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58334

County of Latah
City of Troy Ida

Registration District No. 64
Primary Registration District No. 2744
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hendrix

(a) Residence. No. _____ St. Troy, Idaho

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 14 - 27

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. Still Born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Troy Ida
(State or country)

10 NAME OF FATHER Thomas Hendrix

11 BIRTHPLACE OF FATHER (city or town) Troy Washington
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Tyrell

13 BIRTHPLACE OF MOTHER (city or town) Arkansas
(State or country)

14 Informant Thomas Hendrix
(Address) Troy Ida

15 Filled July 31, 1927 Lucy M. Pickard
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That attended deceased from July 14, 1927 to July 14, 1927
that I last saw him alive on July 14, 1927
and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Meyer M. D.

July 15, 1927 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Bentley cem

July 15, 1927

20. Undertaker

Address

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

766-130-031-453
PLACE OF BIRTH

RECEIVED AUG 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewis

City of Winchester

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 60 State File No. 153849

Hospital _____ Primary Registration District No. 217 Local Registrar's No. 31

FULL NAME OF CHILD None

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June-30</u> 192 <u>7</u> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	--------------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth Four Number of child of this mother now living, including present birth Two

FATHER		MOTHER	
FULL NAME		FULL MAIDEN NAME	
<u>Byrl Thomas Goodwin</u>		<u>May Melton</u>	
RESIDENCE		RESIDENCE	
<u>Winchester Idaho</u>		<u>Winchester Idaho</u>	
COLOR	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR	AGE AT LAST BIRTHDAY <u>30</u> (Years)
<u>White</u>		<u>White</u>	
BIRTHPLACE		BIRTHPLACE	
<u>Illinois</u>		<u>Montana</u>	
OCCUPATION		OCCUPATION	
<u>Laborer</u>		<u>House Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

[Signature]
(Physician or midwife)

Address

Winchester, Idaho

Filled

7/17 1927

R. G. Dunch

Registrar.

Registrar.

[illegible]

There were no other persons shown other evidence of this kind.

541

2. Anteignen Sie

I hereby certify that I attended the birth of this child, who was born at _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

NAME _____
HOMER 3722
OCCUPATION _____
BIRTHPLACE _____
DATE _____

NAME _____
MOTHER
BIRTHPLACE _____
DATE _____

NAME _____
FATHER
BIRTHPLACE _____
DATE _____

RESIDENCE _____
TWO THREE CECILIA
RESIDENCE _____
TWO THREE CECILIA

Number of child in the mother's family present birth _____
Number of child in the mother's family present birth _____

That the child was born in _____
That the child was born in _____

PLATE NAME OF CHILD _____
HOMER 3722

Hospital _____
City of _____
County of _____

CHIEF OF BUREAU OF HEALTH _____
BUREAU OF HEALTH _____
BUREAU OF HEALTH _____

STATE OF OHIO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

(allowing to take away)

(218.400.1)

7-501-24

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 58350

PLACE OF DEATH

CERTIFICATE OF DEATH

County of _____

Registration District No. 60

Local Registrar's No. 13

City of _____

Primary Registration District No. 2129

(No. _____)

If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Steve Born

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

16 DATE OF DEATH June 20 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1927 to June 20, 1927
that I last saw him alive on June 20, 1927
and that death occurred, on the date stated above, at 2:30 m.

6 DATE OF BIRTH (month, day and year) June 30/27
7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH was as follows:

Steve Born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

CONTRIBUTORY (Secondary)

9 BIRTHPLACE (city or town) _____
(State or country)

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) John F. Gust M. D.

19 _____ (Address) Unchinkeddy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

10 NAME OF FATHER Byre Thomas Goodwin

11 BIRTHPLACE OF FATHER (city or town) Id.
(State or country)

12 MAIDEN NAME OF MOTHER May Melton

13 BIRTHPLACE OF MOTHER (city or town) Montez
(State or country)

14 Informant Byre Goodwin
(Address) By. Dr. J. F. Gust - Unchinkeddy

19 Place of Burial, Cremation, or Removal Crematory Id. Date of Burial July 1 1927

20. Undertaker Clyde Clunie Address Crematory Id.

15 Filled 7/17 1927 P. G. Deuch Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth state.

5-59-103-022-113
PLACE OF BIRTH

Tremont
New Dale

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED AUG 11 1927

CERTIFICATE OF BIRTH

153890

hospital or institution

Registration District No. 100 State File No.

Prim. Registration District No. 2178 Local Registrar's No. 173

FULL NAME OF CHILD

Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Boy	Twin Triplet or other?		and	Number in order of birth	Legitimate?	yes	Date of birth	8	3	1927
(To be answered only in event of plural births)											
(Month) (Day) (Year)											

What prophylactic was used to prevent Ophthalmia Neonatorum? Sil

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn yes

FATHER	MOTHER
FULL NAME Ida A. Heibauer	FULL MAIDEN NAME Bertha Leo Jacobs

Residence (Usual place of abode) New Dale

If nonresident, give place and State

Color or race white Age at last Birthday 23 (Years)

Birthplace Teton (City and State or Country)

Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:30 P. M. on the date above stated.

(Signature) Stillborn
M. J. Threlkeld
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payburg, Idaho

Filed 8/6 1927 Registrar

W. E. Kirtell



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

237-238-034-255
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of **Minidoka**

City of **Heyburn**

No. _____ Registration District No. **19** State File No. **153893**

Hospital _____ Primary Registration District No. **2015** Local Registrar's No. **123**

FULL NAME OF CHILD **Baby Blacker**

(Certificate of no value without full name of child)

Sex of Child Girl	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? Yes	Date of birth 6/23 (Month) (Day) (Year) 1927
-----------------------------	---	-------	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth **7** Number of child of this mother now living, including present birth **6**

FATHER

FULL
NAME

Wm Blacker

RESIDENCE

Heyburn

COLOR

White

AGE AT LAST
BIRTHDAY **42**

(Years)

BIRTHPLACE

Wyoming

OCCUPATION

Laborer

MOTHER
FULL
MAIDEN
NAME

Ella Kenyon

RESIDENCE

Heyburn

COLOR

White

AGE AT LAST
BIRTHDAY **36**

(Years)

BIRTHPLACE

Colorado

OCCUPATION

Mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **Stillborn** at **8** A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

M.D.

(Physician or midwife)

Address **Burley, Idaho.**

Filed **7-8** 192**7**

Registrar.

Registrar.

(1) I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

I hereby certify that I attended the birth of this child, who was born at _____ at _____
 on the date above stated.
 (2) When there was no attending physician or midwife, then the father, householder, etc., could make this return. A statement of a child is one that neither prescribes nor shows other evidence of the date of birth.
 (3) Give names added from a supplementary report.

RECEIVED JUL 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58017

PLACE OF DEATH

County of Minidoka
City of HeyburnRegistration District No. 19Primary Registration District No. 2015Local Registrar's No. 18

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Blacker

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) S.5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William J. & Ella K. Blacker6. DATE OF BIRTH (month, day and year) June 23, 19277. AGE Years Months Days Still Born IF LESS than 1 day. hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Heyburn
(State or country) Minidoka Co. Ida.10. NAME OF FATHER William John Blacker11. BIRTHPLACE OF FATHER (city or town) Alamy
(State or Country) Wyoming12. MAIDEN NAME OF MOTHER Ella Kingor13. BIRTHPLACE OF MOTHER (city or town) Colorado
(State or Country)14. Informant William Blacker
(Address) Heyburn Ida15. Filed 6-26, 1927 E. E. Moore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 23, 1927, to June 23, 1927, that I last saw him alive and that death occurred, on the date stated above, at 19 m. The CAUSE OF DEATH* was as follows:Prolapsed Cord

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Moore, M. D.June 23, 1927 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Heyburn Ida. Date of Burial June 24 192720. Undertaker H. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

544-125-03K-713
PLACE OF BIRTH

County of Minnesota
City of Rupert
No. 1010-7 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

153903

Registration District No. 19 State File No. 153903
(If born in hospital or institution give name.) Prim. Registration District No. 2015 Local Registrar's No. 12

FULL NAME OF CHILD (Stillbirth)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 25</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead Stillborn

FATHER FULL NAME <u>Roy Monroe Humphries</u>	MOTHER FULL MAIDEN NAME <u>Zillah Naomi Catmull</u>
---	--

Residence (Usual place of abode) Rupert

If nonresident, give place and State

Color or race white Age at last Birthday 29 (Years)

Birthplace North Carolina (City and State or Country)

Occupation Carpenter

Color or race white Age at last Birthday 29 (Years)

Birthplace Utah (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn 3:55 P M.
on the date above stated.

(Signature) Leland H. Hays

(Physician or midwife)

Address Rupert, Idaho

Filed 8-5 1927 W. H. Hays

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

王德林在台上

Registration District No. State of

Memorandum for the Director, FBI

There is more to "freedom" than just the right to life (1)

[Faint, mostly illegible text from bleed-through or scanning artifacts]

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother including present birth	Born alive and now living

CONFIDENTIAL

[Faint, illegible markings]

SECRET

[Faint, illegible text at the bottom of the page]

11. 11. 11. 11.

1954/2/1

City and State of (Country)

Page 1 of 1

SECRET

1. I am not a member of the Communist Party, nor have I ever been a member of the Communist Party.

(Signature)

There was no attending physician

...should make the return.

child is one that neither breathes nor

[illegible]

*Where there was no attending physician or midwife, then the father, householder, etc., should make the return. A child is one that neither breathes nor shows other signs of life.

THROUGH THE MIDDLE OF THE DAY, THE BIRDS WERE
NOT SHARP BUT BUILT UPON THE BIRDS AND WERE NOT SHARP
LATER, AFTER THE BIRDS WERE NOT SHARP AND WERE NOT SHARP

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

818-204-034-819
PLACE OF BIRTH
County of Idaho
City of Idaho
No. _____ St. _____
Registration District No. 19 State File No. 153911
(If born in hospital or institution give name.)
Prim. Registration District No. 2015 Local Registrar's No. 145
FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Sex of Child girl Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? yes Date of birth 8 4 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn yes

FATHER FULL MAIDEN NAME MOTHER
Obed Crosby Haycock Mary Harding

Residence (Usual place of abode) Idaho Idaho

If nonresident, give place and State Idaho Idaho

Color or race white Age at last Birthday 26 white Age at last Birthday 26
(Years) (Years)

Birthplace Idaho Idaho
(City and State or Country) (City and State or Country)

Occupation College teacher housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

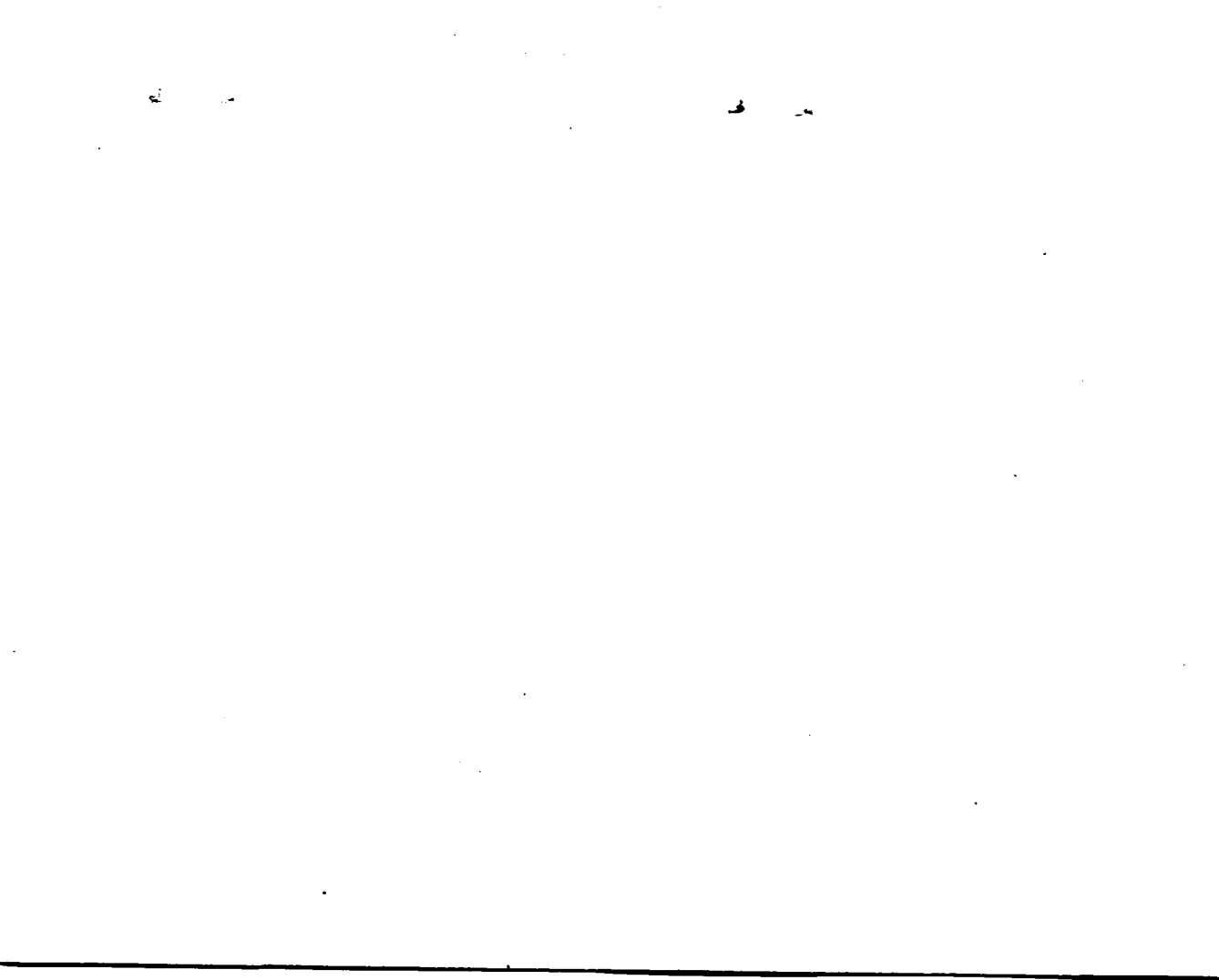
I hereby certify that I attended the birth of this child, who was Born alive at 1:15 P. M. on the date above stated.

(Signature) E. E. Kenagy

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Idaho

Filed 8-9 1927 E. E. Kenagy
Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58362

PLACE OF DEATH

County of MinedokaCity of RupertRegistration District No. 19Primary Registration District No. 2015Local Registrar's No. 19

RECEIVED AUG 10 1927

(No. _____)
If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Haycock

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX F 4. COLOR OR RACE W 5. Single Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug. 4, 19277. AGE Years Months Days Still Born If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rupert
(State or country)10. NAME OF FATHER Obed C. Haycock11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Mary Harding13. BIRTHPLACE OF MOTHER (city or town) Malad Idaho
(State or Country)14. Informant O. C. Haycock
(Address) Rupert Idaho15. Filed 8-3-27 Att. H. H. H.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 19 27

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? _____

(Signed) F. H. Kenney M. D.8-5, 1927 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Idaho Date of Burial Aug 5-192720. Undertaker H. E. Johnson Address Rupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
 and the number of each, in order of birth stated.

385-124-035-385

PLACE OF BIRTH

City of *My Peru*City of *Gifford*

No. _____ St.

Hospital _____

FULL NAME OF CHILD

Sex of
Child*m*Twin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?*yes*Date of
Birth*7**24**19 27*

(Month) (Day) (Year)

FULL
NAME*S. J. Chermak*

FATHER

RESIDENCE

Gifford

COLOR

Wh

AGE AT LAST

40

BIRTHDAY

(Years)

BIRTHPLACE

Bohemia

OCCUPATION

*farmer*FULL
MAIDEN
NAME*Kate Chermak*

MOTHER

RESIDENCE

Gifford

COLOR

Wh

AGE AT LAST

40

BIRTHDAY

(Years)

BIRTHPLACE

New York

OCCUPATION

*house*Number of child of this mother, including present birth. *8* Number of children of this mother now living, including present birth. *7*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *still born* at *1* *a* *M.*
 on the date above stated. (Born alive or still born)

*When there was no attending physician or
 midwife then the father, householder, etc.,
 should make this return. A stillborn child is
 one that neither breathes nor shows other evi-
 dence of life after birth.

(Signature)

E. E. Watts

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

*7-24*19 *27**E. E. Watts*

Registrar

Registrar

STATE OF IDAHO
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 153914
 11

RECEIVED AUG 8 1927



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 8 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of *Way Pover*
City of *Sifford*

Registration District No. *92*
Primary Registration District No. *2170*
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *58375*
Registered No. *58375*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *infant Chermak*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *m* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write the word.)

16. DATE OF DEATH
July *24* *1927*
(Month) (Day) (Year)

6. DATE OF BIRTH
July *24* *1927*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *19* that I last saw him alive on *19* and that death occurred on the date stated above, at *1 a.* M.

7. AGE
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:
Still born from overwork

8. OCCUPATION
(a) Trade, profession or particular kind of work. *none*
(b) General nature of industry, business or establishment in which employed (or employer)

(Duration) Yrs. mos. ds.

9. BIRTHPLACE
(State or Country) *Sifford Idaho*

Contributory (Secondary)

10. NAME OF FATHER *S. J. Chermak*

(Duration) yrs. mos. ds.

11. BIRTHPLACE OF FATHER
(State or Country) *Bohemia*

(Signed) *E. E. Watts* M. D.

12. MAIDEN NAME OF MOTHER *Kate Chermak*

(Address) *Sifford Ida*

13. BIRTHPLACE OF MOTHER
(State or Country) *New York*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *S. J. Chermak*
(Address) *Sifford*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

15. Filed *7-24-1927* *E. E. Watts*
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Myrtle Ida* DATE OF BURIAL *7-24-1927*

20. UNDERTAKER *S. Chermak Acting* ADDRESS *Sifford*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

765717-036-743
PLACE OF RECEIVED AUG 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

153929

County of Owyhee

City of Stone

No. _____ St. _____ Registration District No. 26 State File No. _____

Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 105

FULL NAME OF CHILD Baby Roe

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>July 17</u> 192 <u>7</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? none Stillbirth

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>William Ray Roe</u>	<u>Stone Idaho</u>	<u>Lola E. Pack</u>	<u>Stone Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Stone Idaho</u>		BIRTHPLACE <u>Millard Co Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Stone on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Deedre Leigh M.D.

(Physician or midwife)

Address Nowville Utah

Filed 7/31 1927

Registrar.

Registrar.

DEPT. OF HEALTH
 DIVISION OF VITAL STATISTICS
 BUREAU OF VITAL STATISTICS
 STATE OF NEW YORK
 COUNTY OF ...
 CITY OF ...
 DISTRICT OF ...
 No. ...
 Registered ...
 Primary Registration District No. ...
 Local Registrar's No. ...
 Date of ...
 Date the No. ...
 CERTIFICATE OF ...
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH
 STATE OF NEW YORK

Give names and date of a supplemental report.
 Shows other evidence of life after birth.
 Child is one that neither survives nor
 should make this report. A stillborn
 or midwife than the latter householder
 When there was no attending physician
 on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ... at ...

(Physician or midwife)

(Signature)

Address

Filed

192

OCCUPATION

OCCUPATION

BIRTHPLACE

BIRTHPLACE

AGE AT LAST BIRTHDAY

COLOR

RESIDENCE

RESIDENCE

FULL NAME

FATHER

FULL MAIDEN NAME

MOTHER

Number of child of this mother, including present birth

Number of child of this mother, now living, including present birth

What bacteriological solution was used in exam

(To be answered only in case of special findings)

CRIB

Health

Date of birth

(Days)

(M)

404
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 5 1927 CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Paerda*
 County of *Paerda*
 City of *Stone*
 Registration District No. *26*
 Primary Registration District No. *2069*
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *58380*
 Registered No. *30*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Baby Roe*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. *Single*
 (Write the word.)

6. DATE OF BIRTH *July 17 1927*
 (Month) (Day) (Year)

7. AGE _____ If LESS than 1 day how many _____ hrs. or _____ min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE *Stone Idaho.*
 (State or Country)

10. NAME OF FATHER *Jm Roy Roe*

11. BIRTHPLACE OF FATHER *Stone Idaho.*
 (State or Country)

12. MAIDEN NAME OF MOTHER *Lola E. Roe*

13. BIRTHPLACE OF MOTHER *Millard Co Utah*
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jm Roy Roe*
 (Address) *Stone Idaho*

15. _____

Filed *7-31* 19*27* *J M Kerns*
 Local Registrar

16. DATE OF DEATH *July 17 1927*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 17 1927* to *July 17 1927*
 that I last saw him alive on *July 17 1927*
 and that death occurred on the date stated above, at *3:58* P.
 The CAUSE OF DEATH* was as follows:

Stillbirth
 (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
 (Duration) _____ Yrs. _____ mos. _____ ds.
 (Signed) *Roe* *Sardughan* M. D.
 7/17/1927 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days
 Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Shovelville Utah* DATE OF BURIAL *July 17 1927*

20. UNDERTAKER *Joe J. Larkin* ADDRESS *Shovelville Utah*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

254-3281-036-513
PLACE OF BIRTH

RECEIVED AUG 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 153934

County of Oneida

City of Trinidad

No. _____ St. _____ Registration District No. 26 State File No. _____

Hospital Community Primary Registration District No. 2069 Local Registrar's No. 110

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>7-28</u> 192 <u>7</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FATHER		MOTHER	
FULL NAME	<u>Lorenzo Lundson</u>	FULL MAIDEN NAME	<u>Eliza Halford</u>
RESIDENCE	<u>Portage ut.</u>	RESIDENCE	<u>Portage ut.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>36</u> (Years)	AGE AT LAST BIRTHDAY	<u>34</u> (Years)
BIRTHPLACE	<u>Portage ut.</u>	BIRTHPLACE	<u>Portage ut.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

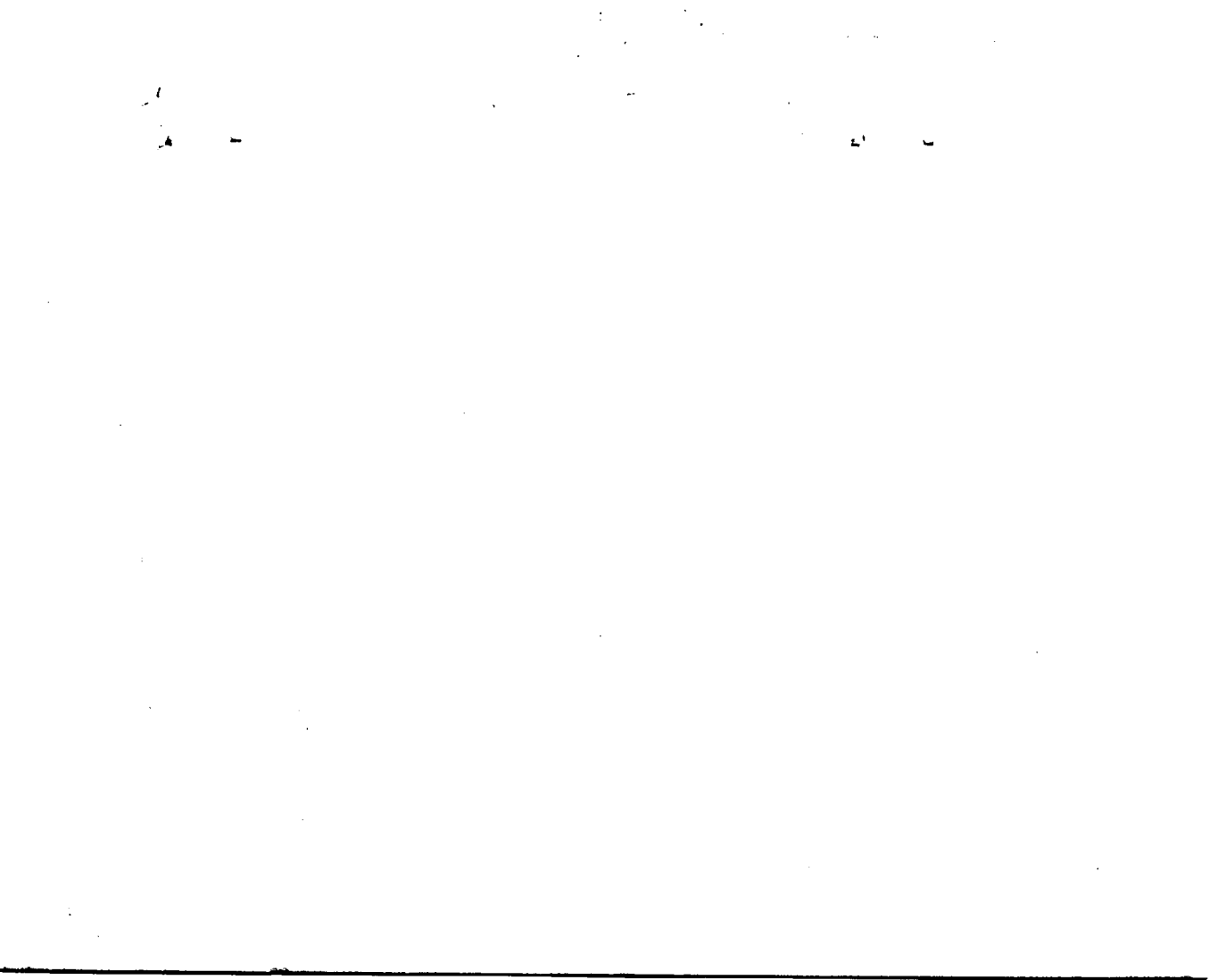
(Physician or midwife)

Address

Filed

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF RECEIVED AUG 5 1927
Registration District No. 26
County of Quincy
City of Malad
Primary Registration District No. 2069
(No. _____ St.)

File No. 55382
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Still Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH

July 28 1927
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?
..... Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Malad Idaho

10. NAME OF FATHER

Harry Lorenzo Knudsen

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Eliza Halford

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorenzo Knudsen
(Address) Malad Idaho

15.

Filed 7-31 1927 J. M. Kern
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1927 to July 28 1927
that I last saw h. at home and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born.
Placenta previa
Delivery

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Kern M. D.

1927 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Portage Utah July 29 1927

20. UNDERTAKER

J. L. Brown Malad Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework; or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

994-10-039-925
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Power

City of Am. Falls

RECEIVED AUG 9 1927

CERTIFICATE OF BIRTH **153956**

No. St. Registration District No. 25 State File No.

Hospital Primary Registration District No. 2072 Local Registrar's No. 1018

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 10 1927</u> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	--------------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 6

FULL NAME <u>Adam Zimmerman</u>	FATHER
RESIDENCE <u>Am. Falls, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>Barbara Isner</u>	MOTHER
RESIDENCE <u>Am. Falls, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) V. B. Logan M.D.
P. S.
(Physician or midwife)

Address Am. Falls, Idaho

Filed 8-8 1927 Genevieve Nolt
Registrar.

Registrar.

Registrar.

CERTIFICATE OF BIRTH

No. _____
Registration District No. _____
County _____
Primary Registration District No. _____
Local _____

NAME OF CHILD _____
(Certificate of no value without full name of child)

Sex of Child _____
Date of Birth _____
Place of Birth _____
To be answered only in event of legal dispute

What bacteriological collection was made in case _____
Number of child of this mother, including present birth _____

NAME FULL NAME OF FATHER _____
NAME FULL NAME OF MOTHER _____
Number of child of this mother now living, including present birth _____

RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____

BIRTHPLACE _____
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

From there are no attending physician _____
and midwife then the father, householder _____
and should make this report. A midwife _____
child is one that neither mother nor _____
shows other evidence of the after birth _____

Give names added from a supplemental report _____
100

Address _____
Signed _____
105

(Physician or midwife)

100

105

100

105

100

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Power
City of Am. FallsRegistration District No. 237
Primary Registration District No. 2072
(No. _____, _____ St.)File No. 58399
Registered No. 320

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white

(Write the word.)

6. DATE OF BIRTH

July 10
(Month) (Day) (Year)1927
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Am. Falls, Ida

10. NAME OF FATHER

Adam Zimmerman

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Barbara Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. V. G. Logan M. D.19 (Address) Am. Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

113. 119. 040-743

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

RECEIVED AUG 15 1927

CERTIFICATE OF BIRTH

S 154014

County of Smyth

City of Wallace

Registration District No. 70

File No. _____

No. _____ St. _____

Primary Registration District No. 1011

Registered No. 68

Hospital Providence

FULL NAME OF CHILD _____

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	Number and in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>July 19 1917</u> Month (Day) (Year)
--------------------------	---	------------------------------------	------------------------	---

FULL NAME N. B. Jackson
FATHER
RESIDENCE Wallace
COLOR W
AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Oklahoma
OCCUPATION miner

FULL MAIDEN NAME Lucia Palana
MOTHER
RESIDENCE Wallace
COLOR W
AGE AT LAST BIRTHDAY 20
(Years)
BIRTHPLACE Montana
OCCUPATION St. M.

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn July 19 at 6:10 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. S. Stone mid.

(Physician or midwife)

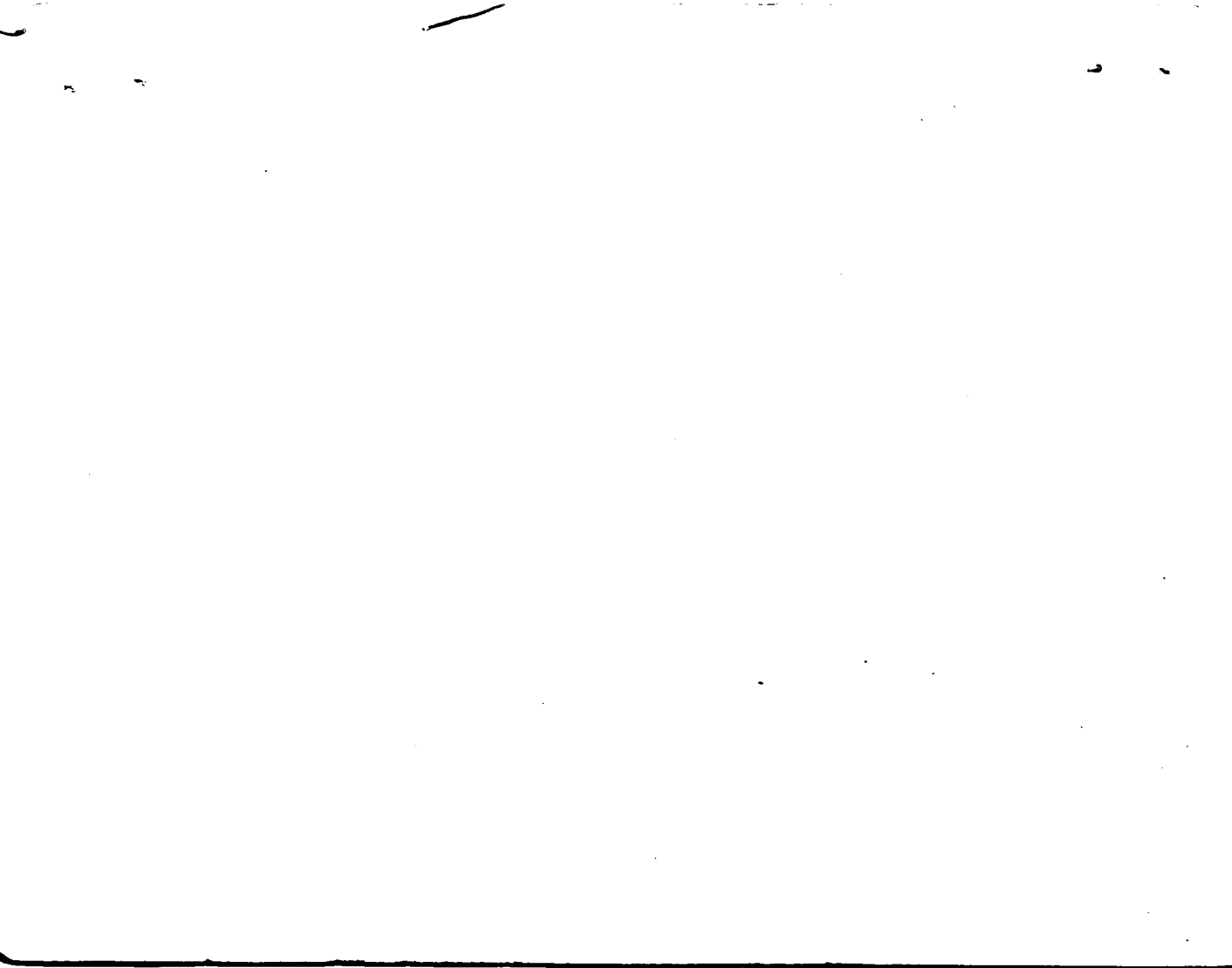
Given names added from a supplemental report.

_____ 19 _____

Address _____

_____ 1927

Filed Aug 1 1927



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58448

RECEIVED AUG 15 1927

PLACE OF DEATH

County of Shoshone

Registration District No. 70

City of Wallace

Primary Registration District No. 1011

Local Registrar's No. 12

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Norman Homer Jackson Jr.

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

none

6 DATE OF BIRTH (month, day and year)

July 19th 1927

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Wallace Idaho

10 NAME OF FATHER

Norman B. Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

North Dakota

12 MAIDEN NAME OF MOTHER

Hilda Palana

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Minnesota

14 Informant

Norman B. Jackson

(Address)

Wallace Ida

15 Filed

July 20, 1927

Dr. S. S. Smith

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Still born

(Month)

(Day)

July

1912

1927
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

not apparent

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oraloni, M. D.

July 20th, 1927 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wallace Ida

July 20 1927

20. Undertaker

R. S. Smith

Address

Hard Und Co

Wallace Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

295-109-042-219
PLACE OF BIRTH

County of Twin Falls
City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 37 State File No. 154048
Hospital J. F. Co. & Son Primary Registration District No. 1085 Local Registrar's No. _____
FULL NAME OF CHILD Jamies Elmer Kreegh
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth 1st Legiti- mate? yes Date of birth July 9 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

FATHER		MOTHER	
FULL NAME	<u>Ernest LaVerne Kreegh</u>	FULL MAIDEN NAME	<u>Elizabeth Blossom Barner</u>
RESIDENCE	<u>Filer, Ida R#1</u>	RESIDENCE	<u>Filer, Ida R#1</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>32</u> (Years)	AGE AT LAST BIRTHDAY	<u>30</u> (Years)
BIRTHPLACE	<u>Delphos Kansas</u>	BIRTHPLACE	<u>Parkston, S. Dak.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5:13 P. M. on the date above stated. Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1927

(Signature) [Signature]

(Physician or midwife)

Address _____

Filed 8-10 1927

Registrar.

Registrar.

SECRET

LETTER TO THE A3PTTUNG

10-10-68

(Certificate of no value without name of child)

(Advised laundries to share in the business of AT)

Number of child of this mother now living, including deceased: 1

THE TEAM

NOTHER

TRAJTA
YANTIDE

TRAJTA FOR
YACHTS

30 JAN 1971

NOTARION

CERTIFICATE OF ATTENDING PHYSICIAN OR NURSE

SECRET

There were no other persons in the room at the time of the shooting. The only person who was in the room at the time of the shooting was the person who was shot.

(STANDARD)

(911-1111 to 1-800-1111)

NOTES

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 23 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58746

Local Registrar's No.

PLACE OF DEATH
County of Juniata Falls
City of Juniata Falls

Registration District No. 39Primary Registration District No. 2087(No. _____)
(If death occurred in a hospital or institution give its name instead of street and number.)2. FULL NAME Not Named (Still Born)

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years X Months X Days X
If LESS than 1 day, ____ hrs. ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Juniata Falls Ida
(State or country)10 NAME OF FATHER Vernon Kreigh11 BIRTHPLACE OF FATHER (city or town) Kansas
(State or country)12 MAIDEN NAME OF MOTHER Klossner13 BIRTHPLACE OF MOTHER (city or town) South Dakota
(State or country)

14 Informant Vernon Kreigh
(Address) Boyle Id.

15 Filled 7-10 1927
J. N. Murphy
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

1927
(Year)

17 I HEREBY CERTIFY, That I attended deceased Not
from 7/9 1927 to 7/9 1927
that I last saw him alive on 7/9 1927
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Paralysis Respiratory
Not possible to start
respiration (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY Weakness of
(Secondary) of heart (duration) ____ yrs. ____ mos. 2 1/2 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C. J. Murphy M. D.7/9 1927 (Address) Boyle Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation or Removal Boyle, Ida Date of Burial July 10 192720 Undertaker L. J. Johnson Address Boyle Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

391-228-042-469
PLACE OF BIRTH

County of Twin Falls RECEIVED AUG 1 1927
City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____
L. F. Co + Gen. Hosp. Registration District No. 37 State File No. 154055
(If born in hospital or institution give name.)

Prim. Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Mary Alice Craig
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>July 28</u> 19 <u>27</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 25%

Number of child of this mother, including present birth 4 (a) Born alive and now living 1
Born alive but now dead 1 Stillborn 2

FATHER	MOTHER
FULL NAME <u>Orville William Craig</u>	FULL MAIDEN NAME <u>Mable Marisset</u>
Residence (Usual place of abode) <u>143 Addison Ave</u>	Residence (Usual place of abode) <u>143 Addison Ave</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>26</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>24</u> (Years)
Birthplace <u>Nodaway Co. Mo.</u> (City and State or Country)	Birthplace <u>Bellevue Mo</u> (City and State or Country)
Occupation <u>Mechanical Engineer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 P. M. on the date above stated.

(Signature) Dr. C. A. Emmer

(Physician or midwife)

Address Twin Falls, Idaho

Filed 8-10 1927 John F. Hays Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

673-219,001-231
PLACE OF BIRTH

RECEIVED SEP 8 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S B

154126

County of Ada

City of Boise

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 2 State File No. _____

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 282

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Fe</u>	<u>Twin Triplet or other?</u> } and { <u>Number in order of birth</u> } <u>Legitimate?</u> <u>Yes</u>	Date of birth <u>8-19-27</u> <u>192</u> (Month) (Day) (Year)
(To be answered only in event of plural births)		

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Wm. R. Ogle
RESIDENCE Glenn's Ferry, Idaho
COLOR W. AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Ohio
OCCUPATION Postmaster

MOTHER
FULL MAIDEN NAME Byrnie Blackwell
RESIDENCE Glenn's Ferry, Idaho
COLOR W. AGE AT LAST BIRTHDAY 33
(Years)
BIRTHPLACE Mountain Home.
OCCUPATION Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192

(Signature) A. J. Coats
Physician
(Physician or midwife)

Address Boise, Idaho

Filed 8/22/27 192 Paula McDonald
Registrar. Registrar.

Registration

Filed

Address

Physician or Midwife

(Signature)

When this child was born, the attending physician or midwife was Dr. J. H. Smith, A. B. M. D., of the City of New York. A full and correct record of the birth of this child is being made by the attending physician or midwife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the 10th day of May, 1910, at 10:30 A. M.

OCCUPATION

BIRTHPLACE

COLORED

John's body, 10:30

RESIDENCE

John's body, 10:30

MALE

NOTED

AGE AT LAST BIRTHDAY

John's body, 10:30

POSTTEST AT

OCCUPATION

BIRTHPLACE

36

This statement is true and correct to the best of my knowledge and belief.

and in presence of

Witness

Date of

Statement of no other child born to same mother

21

Registration Number

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 584773

PLACE OF DEATH

RECEIVED SEP 8 1927

County of Boise
City of Boise

Registration District No. 1

Primary Registration District No. 1004

Local Registrar's No. 191

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Baby, Ogle
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 19, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho
(State or country)

10. NAME OF FATHER Am R Ogle

11. BIRTHPLACE OF FATHER (city or town) Uplandville, Ohio
(State or country)

12. MAIDEN NAME OF MOTHER Brynn Blackwell

13. BIRTHPLACE OF MOTHER (city or town) Mountain Home, Idaho
(State or country)

14. Informant Am R Ogle
(Address) Glenns Ferry, Idaho

15. Filed 8/22/27 19 Paula McQuinn
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August, 19, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw her alive on _____, 19____
and that death occurred, on the date stated above, at _____m.
The CAUSE OF DEATH* was _____ follows:

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? Autopsy
(Signed) A. Coats, M. D.
8-20-27 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 8-20-27

20. Undertaker Am R Ogle Address Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Sp. Dettenger, V. Coates

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

713-107.0 01-432
PLACE OF BIRTH

RECEIVED SEP 8 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of Boise

CERTIFICATE OF BIRTH 154138

No. 1719 Idaho St. Registration District No. 2 State File No. 2

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 294

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and { Number in order of birth Legiti- mate? yes Date of birth 8-3-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth None

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Burrill Gallaher</u>	<u>1709 Idaho</u>	<u>Hyacinth McBride</u>	<u>1709 Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Iowa</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Employee at Sawmill</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 11:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. J. Carl Hill
(Physician or midwife)

Address 415 Eastman Bldg.

Filed 9/15/27 1927 Paula M. Sorensen
Registrar.

[illegible]

RECEIVED SEP 8 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58467

PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)

Local Registrar's No. 191

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Gallacher

(a) Residence. No. 1704 Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 12th Mo. 8/4/277. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Ida
(State or country)

10. NAME OF FATHER B. L. Gallacher

11. BIRTHPLACE OF FATHER (city or town) Jason
(State or Country)

12. MAIDEN NAME OF MOTHER Hyacinth W. Boide

13. BIRTHPLACE OF MOTHER (city or town) Jason
(State or Country)14. Informant B. H. Banfield
(Address) Boise Idaho15. Filed 8-4-1927 (Lucia McDonald)
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19.

that I last saw him alive on, 19.

and that death occurred, on the date stated above, at 12th Mo. m.

The CAUSE OF DEATH* was as follows:

Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? J. Carl Hill, M. D.
(Signed)

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery 1927
Date of Burial20. Undertaker Schuch & Davis
Address Boise Hill

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of uterine gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

136-119,001-695
PLACE OF BIRTH RECEIVED AUG 17 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
154174
26

County of Ada
City of Prima
No. R. 7, 92 St.
Registration District No. _____ State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD Lester E. Alford
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7 19 1927</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 6 (a) Born alive and now living 5
Born alive but now dead none Stillborn 1

FATHER FULL NAME <u>Lester E. Alford</u> Residence (Usual place of abode) <u>Prima R 2</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>34</u> (Years) Birthplace <u>Miltonvale, Kansas</u> (City and State or Country) Occupation <u>farmer</u>	MOTHER FULL MAIDEN NAME <u>Lerna Freeman</u> Residence (Usual place of abode) <u>Prima R 2</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>36</u> (Years) Birthplace <u>Okeha</u> (City and State or Country) Occupation <u>at home</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 7-15 a - M.
on the date above stated.

(Signature) H. F. Neal

Physician
(Physician or midwife)

Address Meridian, Idaho

Filed 8-16 1927 Roy Musselman

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED
OFFICE OF THE
ATTORNEY GENERAL
WASHINGTON, D. C.

IN REPLY TO LETTER OF

DATE OF RECEIPT
TO THE ATTORNEY GENERAL
FROM THE ATTORNEY GENERAL

RE: [illegible]

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

(NAME) (ADDRESS) (CITY) (STATE) (ZIP)

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

(NAME) (ADDRESS) (CITY) (STATE) (ZIP)

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

TO THE ATTORNEY GENERAL
FROM THE ATTORNEY GENERAL
(NAME) (ADDRESS) (CITY) (STATE) (ZIP)

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

RE: [illegible]

DATE OF RECEIPT

TO THE ATTORNEY GENERAL

FROM THE ATTORNEY GENERAL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 17 1927

PLACE OF DEATH

County of Ada
City of Dwight

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 58492

Local Registrar's No. 184

2. FULL NAME Baby Alford

(a) Residence. No. Dwight St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) ✓

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 19-1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 day, 1 hr.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Dwight
(State or country)

10 NAME OF FATHER Leister E. Alford

11 BIRTHPLACE OF FATHER (city or town) McDonwale Kan
(State or country)

12 MAIDEN NAME OF MOTHER Lurana Freeman

13 BIRTHPLACE OF MOTHER (city or town) Okla.
(State or country)

14 Informant Leister E. Alford
(Address)

15 Filed 7/20, 19. Raymunselman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1927, to July 19, 1927, that I last saw him alive on July 19, 1927, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:

Still birth, breech presentation, strangling
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. F. Neal M. D.
7/19, 1927 (Address) McDonwale Kan

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal 1 Anna Idm Date of Burial 7-20 1927

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

236-123-003-612
PLACE OF BIRTH

RECEIVED AUG 23 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Downey

CERTIFICATE OF BIRTH

154207

No. _____ St. _____ Registration District No. 8 3 State File No. _____

Hospital _____ Primary Registration District No. 2 10 Local Registrar's No. 3 12

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Aug 13</u> 192 <u>7</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 14 Number of child of this mother now living, including present birth None

FULL NAME <u>H C Stone</u>	FATHER
RESIDENCE <u>Cochran Junction, Utah</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Ogden, Utah</u>	
OCCUPATION <u>Telegraph Operator</u>	

FULL MAIDEN NAME <u>Edna Wakley</u>	MOTHER
RESIDENCE <u>Cochran Junction, Utah</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Pocatello, Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Downey, Idaho A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Downey, Idaho

Filed Aug 12 1927

Registrar.

Registrar.

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 222 Rosewood Drive, Danvers, MA 01923
 978-750-8400
 www.copyright.com

STADT HILF

23 Registration District No. 2

Primary Registration District No. 1

CLINTON TO IRVING TROTT

...to be ...

[illegible]

Years of hard work will be rewarded.

...and

submitting, until you return, and to bind to return.

THE
WORLD
WIDE



1997

12/21/54

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SECRET

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED AUG 23 1927**
 County of **Bannock** Registration District No. **2-2**
 City of **Bowman** Primary Registration District No. **2140**
 (No. St.)

File No. **58514**
 Registered No. **1696**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(No Name) Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED
 (Write the word.)

6. DATE OF BIRTH

July 23 1927
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Bowman, Idaho.

10. NAME OF FATHER

J. C. Stone,

11. BIRTHPLACE OF FATHER

(State or Country)

Agden, Idaho

12. MAIDEN NAME OF MOTHER

Edna Wakley

13. BIRTHPLACE OF MOTHER

(State or Country)

Pocatello

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Stone
Cache Junction, Utah

15.

Filled **Aug. 12 1927** **Mary C. Coffin**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 23 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at **4:00 P.M.**

The CAUSE OF DEATH was as follows:

Still Birth 9 months gestation

(Duration) Yrs. mos. ds.
 Contributory (Secondary) **Prolonged difficult labor.**

(Duration) yrs. mos. ds.
 (Signed) **J. H. Eastman, M. D.**
7-23-1927 (Address) **Bowman, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bowman, Idaho. 7-25-1927

20. UNDERTAKER

ADDRESS

None.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

315-1046008-213
PLACE OF BIRTH AUG 18 1927 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
COUNTY OF Ben Lick
CITY OF Montpelier
No. _____ St. _____
Registration District No. 52 State File No. 154267
(If born in hospital or institution give name.)
Prim. Registration District No. 2136 Local Registrar's No. _____
FULL NAME OF CHILD Baby Tanner
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Triplet } and { Number in order of birth } Legitimate? Yes Date of birth Aug 4 - 1927
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? Blue Bony Jewed
Number of child of this mother, including present birth _____ (a) Born alive and now living _____
Born alive but now dead _____ Stillborn _____
FATHER FULL NAME Lewis Dr. Tanner MOTHER FULL MAIDEN NAME Elva Bacon
Residence (Usual place of abode) Montpelier Residence (Usual place of abode) Montpelier
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 34 Color or race White Age at last Birthday 24
(Years) (Years)
Birthplace Utah Birthplace Idaho
(City and State or Country) (City and State or Country)
Occupation Doc. Stenographer Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 P. M.
on the date above stated.

(Signature) N. H. Mang

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Montpelier Idaho

Filed 8/17/1927 N. H. Mang Registrar.

CHINESE THEATREMAN A. J. CHITTY...
not obtain any more. THEATRES RE-OPENED in a
few days and he returns in a
few days.

NOTES TO READER

Registration District No. 2101

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

10-10-68

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(S) [Illegible text]

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10 and 11. The latter two are

10-10-68

1. The first of these is the fact that the Commission has not yet received any information from the Government of the Democratic Republic of the Congo regarding the situation in the country.

RECEIVED AUG 18 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Beaver Lake*
City of *Montpelier*Registration District No. *52*Primary Registration District No. *2132*

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *58518*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

1 Baby Tanner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Aug 4 1927
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Aug 5 1927*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born at 5:30 PM.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Aug 4 1927 (Address) *Montpelier, Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beaumont Id. Aug 5 1927

20. UNDERTAKER

ADDRESS

John Lee *Beaumont Id.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-121010-799
PLACE OF BIRTH

RECEIVED AUG 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville

City of Idaho Falls

CERTIFICATE OF BIRTH

154339

No. Memorial St. Registration District No. 73 State File No. _____

Hospital L. H. S. Primary Registration District No. 2170 Local Registrar's No. 279

FULL NAME OF CHILD Marshall (Stillborn)
(Certificate of no value without full name of child)

Sex of Child <u>m</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>6-21-1927</u> (Month) (Day) (Year)
-----------------------	---	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER		MOTHER	
FULL NAME <u>Edward E. Inger Marshall</u>	FULL MAIDEN NAME <u>Frances L. G. Prief</u>		
RESIDENCE <u>169 E. 15th St. city.</u>	RESIDENCE <u>169 E. 15th city.</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Sage City Idaho.</u>	BIRTHPLACE <u>Idaho Idaho.</u>		
OCCUPATION <u>clerk</u>	OCCUPATION <u>housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at Idaho Falls, M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192____

(Signature) [Signature]
(Physician or ~~midwife~~)

Address Idaho Falls Idaho.

Filed 7/29 1927 [Signature]
Registrar.

1. NAME (Last, First, Middle)
 2. DATE OF BIRTH (Month, Day, Year)
 3. SEX (Male, Female)
 4. RACE (White, Black, Other)
 5. RELIGION (Catholic, Protestant, Jewish, Muslim, Other)
 6. OCCUPATION (Student, Teacher, Doctor, Nurse, Other)
 7. ADDRESS (Street, City, State, Zip)
 8. PHONE NUMBER (Area Code, Number)
 9. SIGNATURE (Printed Name)
 10. DATE (Month, Day, Year)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 58565

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner Registration District No. 73
City of Idaho Falls Primary Registration District No. 2117

Local Registrar's No. 79

(No. _____)
(If death occurred in a hospital or institution give its name instead instead of street and number.)

2. FULL NAME Marvin E. Marshall

(a) Residence. No. _____ St. _____

(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

16 DATE OF DEATH June 21 1927
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from June 21 1927 to June 21 1927
that I last saw him alive on _____ 19____
and that death occurred, on the date stated above, at 6 P. m.

6 DATE OF BIRTH (month, day and year)

The CAUSE OF DEATH* was as follows:
Asphyxia Cordis

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.
no no no no

CONTRIBUTORY (Secondary) Congenital Mitral Stenosis

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None

(duration) ____ yrs. ____ mos. ____ ds.

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

(duration) ____ yrs. ____ mos. ____ ds.

9 BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho

18 Where was disease contracted If not at place of death? ✓

10 NAME OF FATHER Ed. Marshall

Did an operation precede death? no Date of ✓

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scott City La.

Was there an autopsy? no
What test confirmed diagnosis? Inspection no lead
(Signed) W. F. McHan M. D.
June 22, 1927 (Address) Idaho Falls

12 MAIDEN NAME OF MOTHER Rulu

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lons Idaho

19 Place of Burial, Cremation, or Removal Date of Burial
Idaho Falls Idaho June 22 27

14 Informant Ed. Marshall
(Address) 1153 Canal Ave Idaho Falls

20. Undertaker W. F. McHan Idaho Falls

15 Filed 6/22 1927 W. F. McHan Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None,

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

764-132-90-555
PLACE RECEIVED AUG 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville
City of Idaho Falls

CERTIFICATE OF BIRTH 154377

No. Memorial St. Registration District No. 73 State File No. _____
Hospital L. P. L. Primary Registration District No. 242 Local Registrar's No. 242

FULL NAME OF CHILD Gourley (Stillborn)
(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? and { Number in order of birth 1 Legitimate? yes Date of birth 6-20-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Fletcher William Gourley
RESIDENCE 128-15 Idaho Falls Ida.
COLOR white AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Villisca Iowa
OCCUPATION Auctioneer

MOTHER
FULL MAIDEN NAME Myrtle M. Everett
RESIDENCE 128-15 Idaho Falls Ida.
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Idaho Falls
OCCUPATION House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive } at 6:00 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls Ida.
Filed 7/29 1927 [Signature] Registrar.

Registrar.

THIS IS TO CERTIFY THAT THE CHILD NAMED HEREIN WAS BORN AT THE PLACE AND DATE HEREIN SET FORTH AND THAT THE CHILD WAS REGISTERED IN THE BIRTH RECORDS OF THE CITY OF NEW YORK.

COUNTY OF NEW YORK
 CITY OF NEW YORK
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Hospital St. Vincent's
 Primary Registration District No. 100
 Local Registration District No. 100
 State File No. 100

NAME OF CHILD JOHN J. JAMES
 (Certificate of no name without full name of child)
 Sex of Child Male
 Date of Birth 1912
 Place of Birth St. Vincent's
 (No name of child is given at birth)

What pathological condition was noted at birth? None
 Number of child of this mother, including present birth 1
 Number of child of this mother, including present birth 1

FATHER	MOTHER
FULL NAME <u>JOHN J. JAMES</u>	FULL NAME <u>JOHN J. JAMES</u>
RESIDENCE <u>St. Vincent's</u>	RESIDENCE <u>St. Vincent's</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>28</u>	AGE AT LAST BIRTHDAY <u>28</u>
BIRTHPLACE <u>St. Vincent's</u>	BIRTHPLACE <u>St. Vincent's</u>
OCCUPATION <u>None</u>	OCCUPATION <u>None</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the date above stated.
 (Signature) John J. James
 (Physician or midwife)
 Address St. Vincent's
 City St. Vincent's

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

242-102-010-366
PLACE OF BIRTH
RECEIVED AUG 17 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
154381

CERTIFICATE OF BIRTH

County of *Bannock*

City of *Idaho Falls*

No. *399 Cliff* St. Registration District No. *73* State File No. *2*

Hospital *no* Primary Registration District No. *210-0* Local Registrar's No. *262*

FULL NAME OF CHILD

Still Born.

(Certificate of no value without full name of child)

Sex of Child *male* Twin Triplet or other? *x* and { Number in order of birth *x* Legitimate? *yes* Date of birth *5-2-1927*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *3* Number of child of this mother now living, including present birth *1*

FATHER
FULL NAME *Guy. Butler*
RESIDENCE *399 Cliff St.*
COLOR *W.* AGE AT LAST BIRTHDAY *39*
(Years)
BIRTHPLACE *Kanago*
OCCUPATION *Cook*

MOTHER
FULL MAIDEN NAME *Rebecca Fowler*
RESIDENCE *399 Cliff St.*
COLOR *W.* AGE AT LAST BIRTHDAY *23*
(Years)
BIRTHPLACE *Portland Ore.*
OCCUPATION *House Wife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Born alive* at *12-10* P. M.
on the date above stated. *Stillborn*

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *[Signature]*
(Physician or midwife)

Address *Idaho Falls, Ida*

Filed *7/23* 192 *7* Registrar.

Registrar.

Registrar.

RECEIVED JUN 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **57484**

Local Registrar's No. **49**

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21170

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Butler

(a) Residence. No. Idaho Falls, Idaho St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) May 2, 1927

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10 NAME OF FATHER Guy XXX Bxx Butler Guy Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas

12 MAIDEN NAME OF MOTHER Roberta Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oregon

14 Informant Mrs. Roberta Butler
(Address) Idaho Falls, Idaho

15 Filled May 3 19 27 C. J. Manning
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 2 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at 2-30p m.

The CAUSE OF DEATH* was as follows:

Pneumonia 3 mos.
Still Born.

(duration) ____ yrs. ____ mos. ____ da.
CONTRIBUTORY Bronchitis of mother.
(Secondary)

(duration) ____ yrs. ____ mos. ____ da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) C. J. Manning, M. D.
5-3-27 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Rose Hill, Idaho Falls Date of Burial May 3 19 27

20. Undertaker J.A. Wood Address Idaho Falls

should state CAUSE OF DEATH in plain terms, so that it may be properly CUPATION is very important. See instructions on back of certificate.

MAR 23 1992

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

669-102-001-796
PLACE OF BIRTH

STATE DEPARTMENT OF WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Adair
CITY OF Anna R 4
CERTIFICATE OF BIRTH

S

154413

County of Adair RECEIVED SEP 6 1927
City of Anna R 4
No. _____ St. Registration District No. _____ File No. 154413
Hospital _____ Primary Registration District No. _____ Registrar's No. 136

FULL NAME OF CHILD

Dallas Dewayne Torrey
(Certificate of no value without full name of child)

Sex of
Child

M

Twin
Triplet
or other?

}

and {

Number
in order
of birth

}

Legiti-
mate?

Yes

Date of
birth

9-2
(Month) (Day)

1927
(Year)

What bactericidal solution was used in eyes?

Salvarsan

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Albert B Torrey

RESIDENCE

Anna R 4, Ia

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Mauckata Kan

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Pearl Brown

RESIDENCE

Anna R 5

COLOR

White

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

S. C.

OCCUPATION

Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at

30 a M

on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

O. Steelman

(Physician or midwife)

Address

Mauckata Kan

Filed

Sept 1927

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

625-119-022-793

PLACE OF BIRTH

RECEIVED AUG 16 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Ashton

No. 7 St. 2

Registration District No. 10

File No. 154535

Hospital Ashton

Primary Registration District No. 6

Registered No. 154535

FULL NAME OF CHILD

Stillborn, Oberkensch

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>7-19-1927</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Carl A. Oberkensch

MOTHER
FULL MAIDEN NAME Ida Edith Oberkensch

RESIDENCE Ashton Idaho

RESIDENCE Ashton Idaho

COLOR white AGE AT LAST BIRTHDAY 33 (Years)

COLOR white AGE AT LAST BIRTHDAY 28 (Years)

BIRTHPLACE Utah

BIRTHPLACE Idaho

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at Ashton Idaho U.S.A. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ida Edith Oberkensch

(Physician or midwife)

Give names added from a supplemental report.

Address Ashton Idaho

Filed 7/19 1927

Registrar.

Registrar.

RECEIVED BY THE BUREAU OF VITAL STATISTICS, STATE OF IOWA, DES MOINES, IOWA, JANUARY 1, 1917. THIS CERTIFICATE IS NOT VALID UNLESS IT IS FILED IN THE BUREAU OF VITAL STATISTICS, STATE OF IOWA, DES MOINES, IOWA, JANUARY 1, 1917.

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of _____
City of _____
No. _____
Registration District No. _____
Primary Registration District No. _____
Hospital _____
Full Name of Child _____
(Write out in full the name of child)

Sex _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Weight _____
Length _____
Circumference _____

What medicinal solution was used in case? _____
If used, name and strength _____

Full Name _____
Maiden Name _____
Residence _____

Color _____
Age at Last Birthday _____
Birthplace _____

Occupation _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was _____
on the date specified.

Signature _____
Date _____

Give name of doctor from whom supplemental report _____
Date _____

Signature _____
Date _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

331-119-022-483

PLACE OF BIRTH

RECEIVED SEP 12 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of _____
City of Twin Groves, Ida.

No. _____ St. _____

CERTIFICATE OF BIRTH

154536

Registration District No. 99 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2177 Local Registrar's No. 692

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>2</u>	Legiti- mate? <u>yes</u>	Date of birth <u>7</u> <u>19</u> <u>1927</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Acrol

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Albert Stanley Clark

Residence (Usual place of abode) Twin Groves, Ida.

If nonresident, give place and State _____

Color or race White Age at last Birthday 26 (Years)

Birthplace Ammon, Idaho
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Julia Etta Miller

Residence (Usual place of abode) Twin Groves, Ida.

If nonresident, give place and State _____

Color or race White Age at last Birthday 21 (Years)

Birthplace Paig, Idaho
(City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive ✓ Stillborn ✓ at 1 P. M.
on the date above stated.

(Signature) P. M. Kelly, M. D.

(Physician or midwife)

Address St. Anthony, Idaho

Filed 9/8 1927 Ammon

Registrar.

{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 23 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 30927

PLACE OF DEATH

County of

City of

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 232

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. (Usual place of abode)

St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male. White.

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

Infant

5a. married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address)

15. Filed

3/30

1928

W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 19th

(Month)

(Day)

1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19th, 1927, to July 19th, 1927, that I last saw him alive on July 19th, 1927, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Prolapse & constriction of Cord.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) P. M. Kelly M. D.

July 19, 1927 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Baker, Ida. July 19 1927

20. Undertaker

Address

Wm. J. Keller, Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia; "Pneumonia," unqualified, is indefinite; Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis" etc. all diseases resulting from stillbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

S

434-115026-669
PLACE OF BIRTH RECEIVED SEP 6 1927
County of Jefferson
City of Paris
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 98 State File No. 154589

(If born in hospital or institution give name.)

Registration District No. 246 Local Registrar's No. 171

FULL NAME OF CHILD Still-born (Placenta previa)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other <input checked="" type="checkbox"/> (To be answered only in event of plural births)	and {	Number in order of birth <u>1</u>	Legitimated <input checked="" type="checkbox"/>	Date of birth <u>July 15</u> 19 <u>27</u> (Month) (Day) (Year)
-------------------------	--	-------	-----------------------------------	---	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Lawrence J. M. Murray
Residence (Usual place of abode) Paris, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 75 (Years)
Birthplace Wyo
(City and State or Country)
Occupation farmer

MOTHER
FULL MAIDEN NAME Anna E. Forsythe
Residence (Usual place of abode) Paris, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 24 (Years)
Birthplace Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Paris, Idaho on the date above stated.

(Signature) Sam F. Price
Physician
(Physician or midwife)

Address Paris, Idaho
Filed 9-1 1927 E. J. Kavin
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

713-217.028-459
PLACE OR RECEIVED
County of Kootenai
City of Coeur d'Alene
No. Fourth St. St.

AUG 29 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

154622

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>July 17,</u> <u>1927</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Benjamin Patzer

Residence (Usual place of abode) C.d'A., Idaho

If nonresident, give place and State.

Color or race White Age at last Birthday 32
(Years)

Birthplace South Dakota

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Lydia Merkel

Residence (Usual place of abode) C.d'A., Idaho

If nonresident, give place and State.

Color or race White Age at last Birthday 32
(Years)

Birthplace North Dakota

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11 A.M.
on the date above stated.

(Signature) Harold J. Sturges M.D.

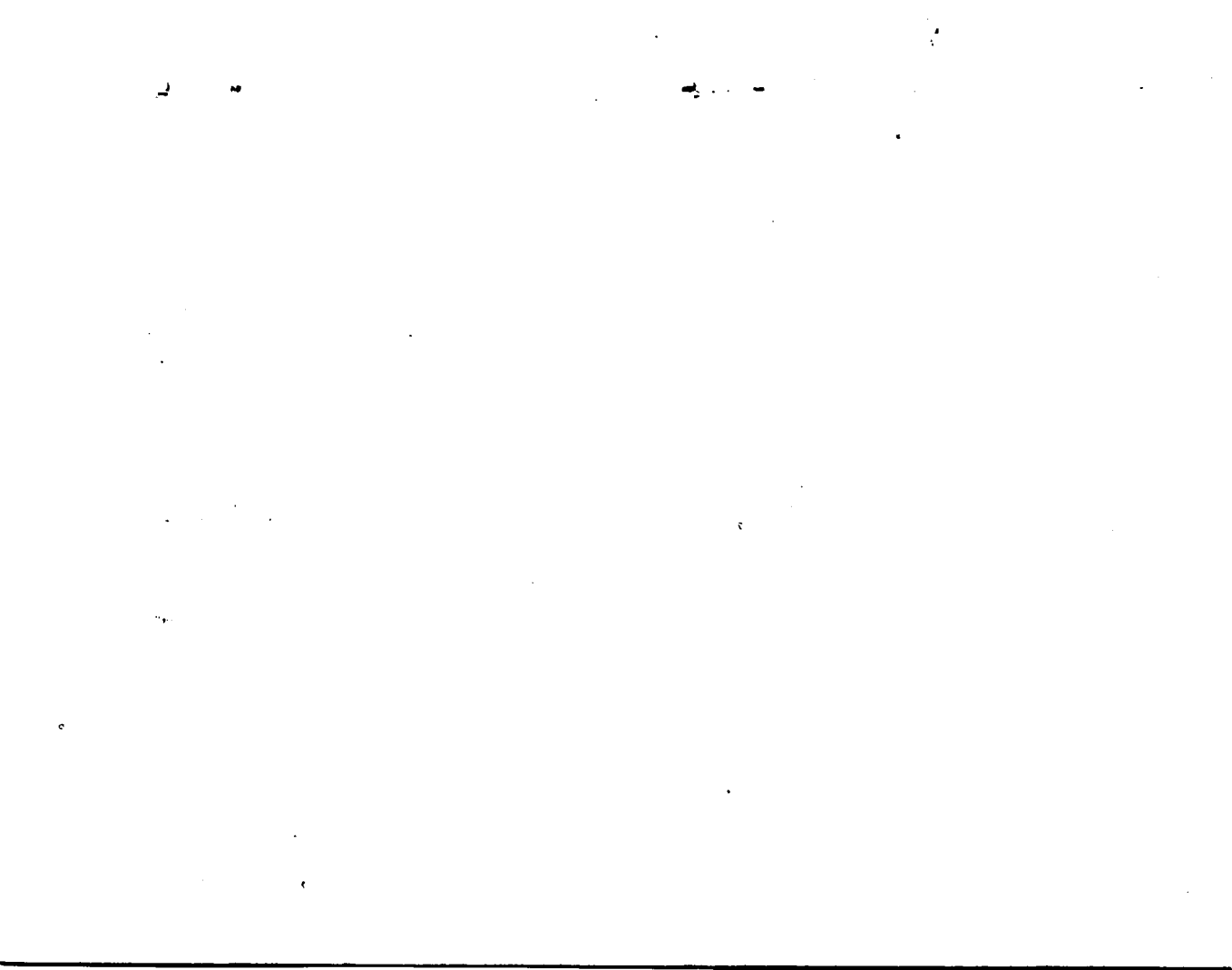
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Coeur d'Alene, Idaho

Filed 7/12 1927 D. J. Jensen

Registrar.



RECEIVED AUG 29 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58643

PLACE OF DEATH

County of Idaho Registration District No.City of Coeur d'Alene Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Patzer(a) Residence. No. C. D. A. Route 2 St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Coeur d'Alene

10 NAME OF FATHER

Benj. Patzer11 BIRTHPLACE OF FATHER (city or town)
(State or country)S. Dak

12 MAIDEN NAME OF MOTHER

Lydia Merkel13 BIRTHPLACE OF MOTHER (city or town)
(State or country)N. Dak

14

Informant
(Address)Benj. Patzer

15

Filed

7/20 1927W. D. Drennan

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July
(Month)17
(Day)1927
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 7, 1927, to July 7, 1927.that I last saw him alive on July 7-17, 1927.and that death occurred, on the date stated above, at P. A. m.

The CAUSE OF DEATH* was as follows:

Placenta previa

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of ____Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

Harold J. Sturges M. D.Aug 18, 1927(Address) Coeur d'Alene*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Adventist Cemetery July 18 1927

20. Undertaker

Address

R. T. Mowrey C. D. A. Id.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

363-129-028- RECEIVED AUG 29 1927

PLACE OF BIRTH 652

County of Kootenai
City of Coeur d'Alene
No. 213 Garden St.

Home Hospital

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

154628

Registration District No. State File No.

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legitimate <u>Yes</u>	Date of birth <u>July 29, 1927</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? -----

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Edward Holmes Cole

Residence (Usual place of abode) C.d'A., Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 29

Birthplace New York, New York (Years)

Occupation Store Manager (City and State or Country)

MOTHER
FULL MAIDEN NAME Luella Onstine

Residence (Usual place of abode) C.d'A., Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 29

Birthplace Highland, Minnesota (Years)

Occupation School Teacher (Housewife) (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 3:40 P. M. on the date above stated.

(Signature) E. J. Olson

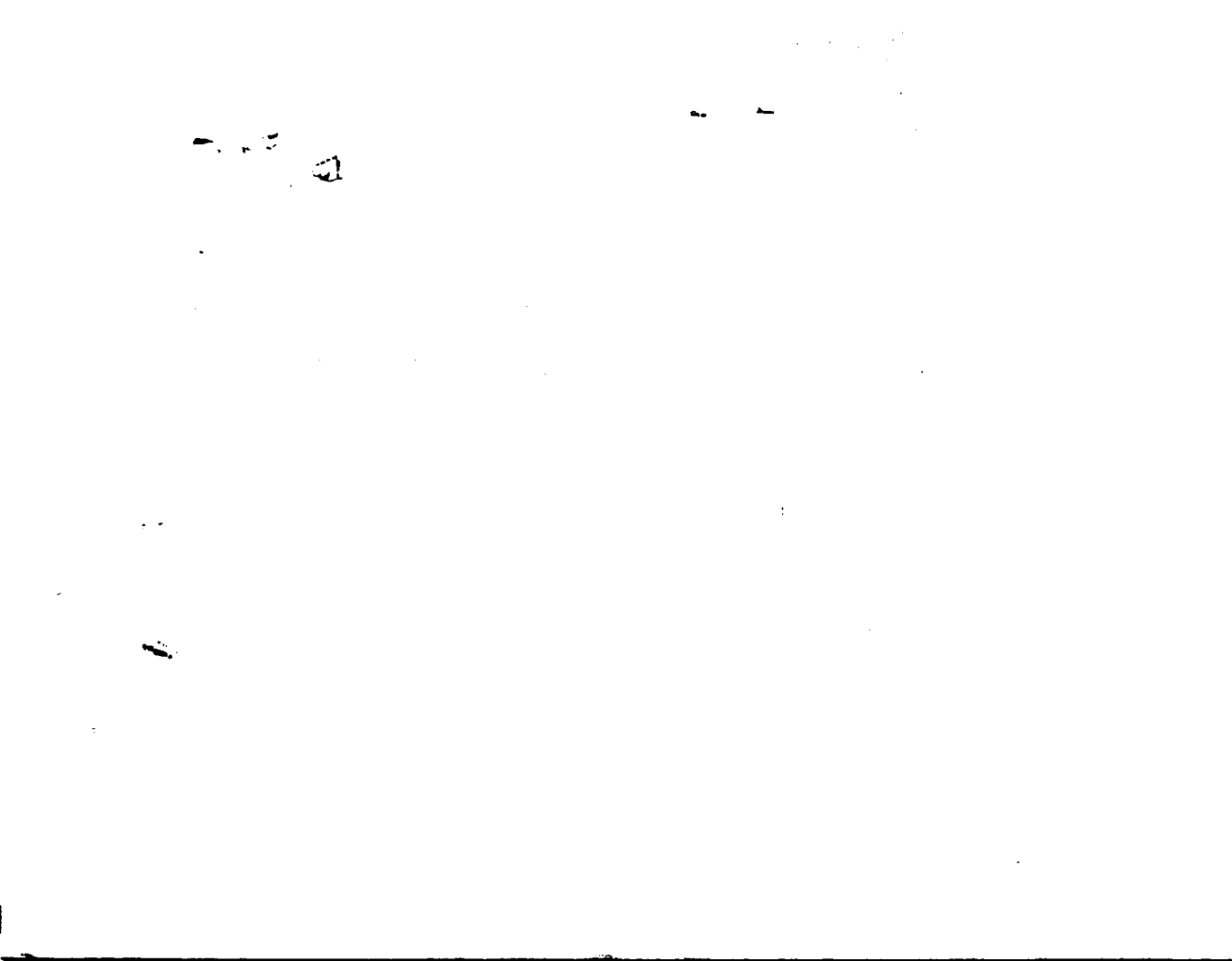
Physician

(Physician or midwife)

Address College Place Wn

Filed 8/12 1927 D. A. Hanna Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 29 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

58647

State File No.

PLACE OF DEATH

County Boise
City of Boise

Registration District No.

Primary Registration District No.

(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Eugene E. Cole

(a) Residence. No. 213 Garden St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) July 29/1927

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Boise
(State or country) Idaho

10 NAME OF FATHER Edward Cole
11 BIRTHPLACE OF FATHER (city or town) Brooklyn
(State or country) New York
12 MAIDEN NAME OF MOTHER Luella Christina
13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Edward Cole
(Address) Boise Idaho

15 Filed 8/4 1927 J. D. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 29 1927 to July 29 1927
that I last saw him Still alive 1927
and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:
Still birth - flat pelvis +
very large head which
would not pass pubis intact
(duration) yrs. mos. ds.

CONTRIBUTORY Contracted pelvis
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Tried to breathe

(Signed) E. D. Spahr M. D.
1927 (Address) College Place
Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial July 31 1927
20. Undertaker R B Mooney Address Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

154-215-029-168
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Latah

City of Troy

CERTIFICATE OF BIRTH 154668

No. _____ St. _____ Registration District No. 64 State File No. _____

Hospital _____ Primary Registration District No. 2144 Local Registrar's No. _____

FULL NAME OF CHILD Maxine Ann Anderson

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Aug 15 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 10% argyrol sol.

Number of child of this mother, including present birth first Number of child of this mother now living, including present birth one

FATHER
FULL NAME Clarence Anderson
RESIDENCE Troy, Idaho
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ellie Johnson
RESIDENCE Troy, Idaho
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at _____ M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. J. Meyer
(Physician or midwife)

Give names added from a supplemental report.
Lucy M. Pickard 1927
Registrar.

Address Troy, Idaho
Filed Sept 8 1927 Lucy M. Pickard
Registrar.

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

4. The fourth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

5. The fifth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

6. The sixth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

7. The seventh part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

8. The eighth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

9. The ninth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

10. The tenth part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

735-216.075-286

PLACE OF BIRTH

AUG 26 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nez Perce
City of Lewiston

CERTIFICATE OF BIRTH

154715

No. _____ St. _____ Registration District No. 96 File No. _____
Hospital St Joseph Primary Registration District No. 1009 Registered No. _____
FULL NAME OF CHILD Birdie Gleason
(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? no and Number in order of birth 1 Legitimate? yes Date of birth 7/16 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Roy Gleason
RESIDENCE Asotin Wash
COLOR W AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Id
OCCUPATION Miller

MOTHER
FULL MAIDEN NAME Birdie Shoner
RESIDENCE Asotin Wash
COLOR W AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Wash
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

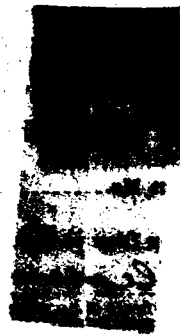
I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) McElrain MD.

Give names added from a supplemental report.
_____, 19_____
Registrar.

(Physician or midwife)
Address Asotin, Wash.
Filed Aug 18 1927 Susan E. Bruce Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instruction on back of certificate.

RECEIVED AUG 24 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58692

PLACE OF DEATH

County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Norma T. Gleason

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) _____

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) July 16-1927

7. AGE Still Born Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Lewiston Idaho (State or country) _____

10. NAME OF FATHER Roy W. Gleason

11. BIRTHPLACE OF FATHER (city or town) Aledo Ill. (State or Country) _____

12. MAIDEN NAME OF MOTHER Berdia Shaner

13. BIRTHPLACE OF MOTHER (city or town) Spokane Wash. (State or Country) _____

14. Informant Roy Gleason (Address) Asotin Wash

15. Filed Aug 22, 1927 Simon E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? J. McElhain M. D.

(Signed) July 17, 1927 (Address) Asotin Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clarkston Wash. Date of Burial 7/17 1927

20. Undertaker H. R. Merchant Address Clarkston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

866-109,035 238

PLACE OF BIRTH

RECEIVED SEP 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nezperce

City of Lewiston

No. _____ St. _____

Registration District No. 96

File No. 154756

Hospital St. Joseph's

Primary Registration District No. 1009

Registered No. _____

FULL NAME OF CHILD Unnamed Hood
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Aug 9</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth. 1st Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME Wm. R. Hood

RESIDENCE Lewiston, Idaho

COLOR White AGE AT LAST BIRTHDAY 23 (Years)

BIRTHPLACE Idaho

OCCUPATION Machinist

MOTHER
FULL MAIDEN NAME Elvira Blyton

RESIDENCE Lewiston, Idaho

COLOR White AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Washington

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 9:40 A. M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Oliver B. Alley
(Physician or midwife)

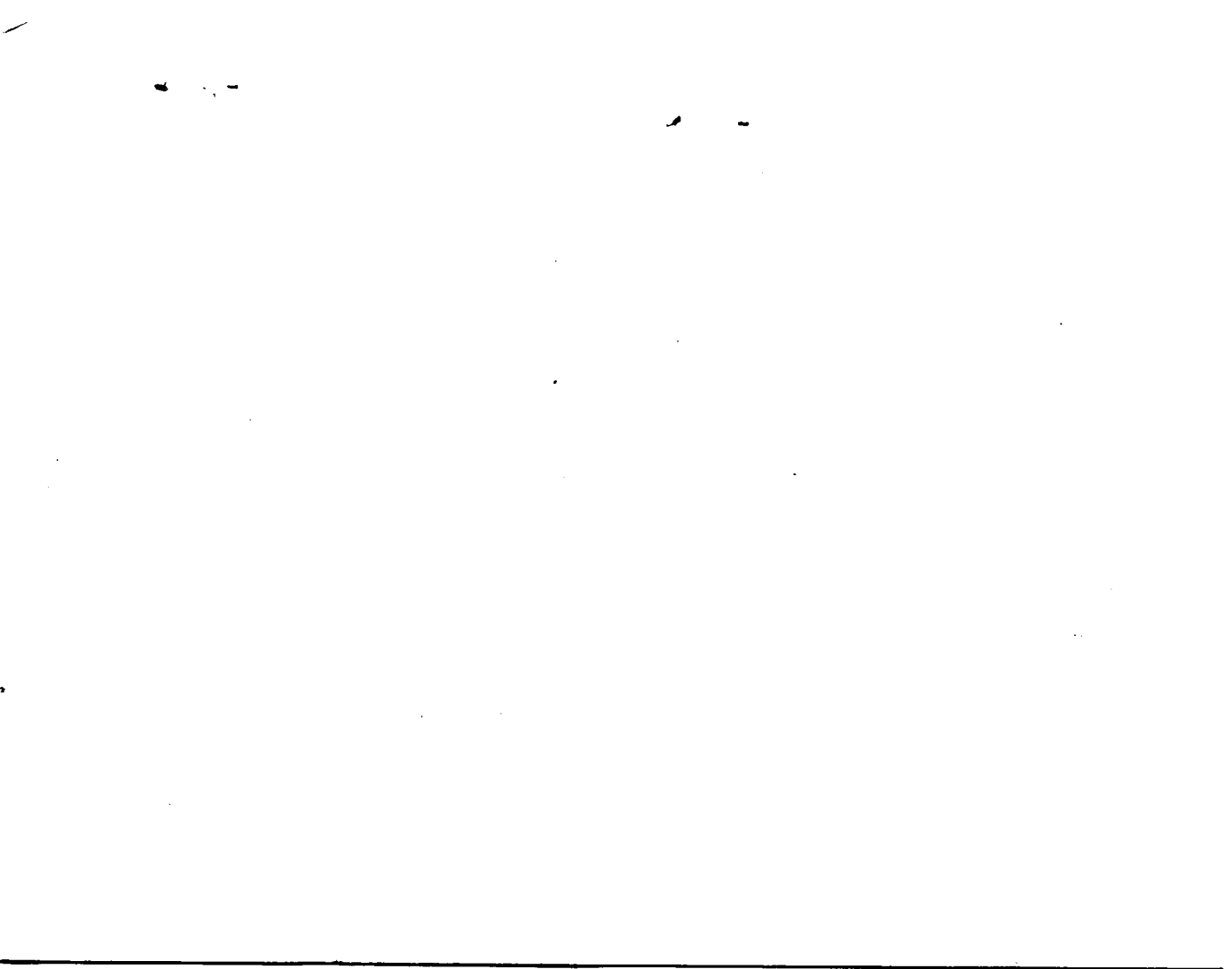
Give names added from a supplemental report.

Address Lewiston, Idaho

Filed Sept 7 1927 Ernest E. Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 24 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58690

County of Myer

Registration District No. 96

City of Lewiston

Primary Registration District No. 1019

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)
No. St. Joseph Hospital

2. FULL NAME Still Born

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Still Born

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Still Born

6 DATE OF BIRTH (month, day and year) Aug 9th 1927

7 AGE Still Born Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Lewiston Idaho (State or country)

10 NAME OF FATHER William R. Hood

11 BIRTHPLACE OF FATHER (city or town) Idaho (State or country)

12 MAIDEN NAME OF MOTHER Elvira Blyton

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country)

14 Informant Oliver Hood (Address) 927-7th St. Charleston W.

15 Filed Aug 23, 1927 Sam E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 9 1927 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1927 to Aug 9, 1927, that I last saw him alive as Still Born, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Still Born (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? (Signed) John H. H. H. M. D. _____ 1927 (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Varner and Co Date of Burial Aug 10 1927

20 Undertaker Lewiston Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicæmia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably such**, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

275-115-240-134
 PLACE OF BIRTH **IDAHO** **SEP 13 1927**

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **154801**

No. 2 St. Registration District No. 70 State File No.
 Hospital Wallace Hospital Primary Registration District No. 1011 Local Registrar's No. 74
 FULL NAME OF CHILD James Speaks
 (Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and { Number in order of birth Legitimacy no Date of birth July 10 1927
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>4th</u>		Number of child of this mother now living, including present birth <u>2</u>	
FATHER		MOTHER	
FULL NAME <u>Frank Carey</u>	FULL MAIDEN NAME <u>Edna Aldrich</u>		
RESIDENCE <u>Kellogg</u>	RESIDENCE <u>Kellogg</u>		
COLOR <u> </u>	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>miner</u>	OCCUPATION <u>House wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Wallace Hospital on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. W. Verne M.D.

(Physician or midwife)

Give names added from a supplemental report. , 1927

Address Wallace Idaho
 Filed Aug 23 1927 R. L. Linsley
 Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



11

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 15 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

00100

State File No.

PLACE OF DEATH

County of Shoshone
City of Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 90

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME man

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wallace
(State or country)

10 NAME OF FATHER Sam Sparks

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

KENT

12 MAIDEN NAME OF MOTHER

Maria Ladigo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

IOWA

Iowa

14 Informant Frank Barry
(Address) Kallogg Idaho

15 Filed July 15 1927

C. L. Quigley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 15 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. B. Rulerick, M. D.

July 15, 1927 (Address) Wallace Idaho

State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wallace, Idaho July 15 1927

20. Undertaker

Address

Bruce S. Morrell Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

4331191003-338
PLACE OF BIRTH

RECEIVED OCT 11 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Barnett
City of Lava Hot Springs

CERTIFICATE OF BIRTH 154986

No. _____ St. _____ Registration District No. 84 State File No. _____

Hospital _____ Primary Registration District No. 2161 Local Registrar's No. 399

FULL NAME OF CHILD Stewart M. C. Clure

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 19</u> 192 <u>7</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? 10.70 Neo-silvol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Kenneth Frederic Doyle M. C. Clure
RESIDENCE Lava Hot Springs Ida
COLOR White AGE AT LAST BIRTHDAY 20 (Years)

BIRTHPLACE Crescent Iowa
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Opal Clymer
RESIDENCE Lava Hot Springs Ida
COLOR White AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Logan Colo.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 8:35 Am M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) A. Rich

(Physician or midwife)

Address Lava Hot Springs Ida

Filed 9/6 1927 Mrs J. G. Fitz Registrar.

Registrar.

AUG 31 1943

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

356-128.003-897
PLACE OF BIRTH
RECEIVED OCT 11 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Bannock
City of Lava Hot Springs
No. 84 St. Registration District No. 84 State File No. 154997
Hospital Municipal Sanitarium Primary Registration District No. 2161 Local Registrar's No. 410
FULL NAME OF CHILD Grant Lewis

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> } and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 28</u> 192 <u>7</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Le Roy Wilford Lewis</u>	<u>Bancroft Idaho</u>	<u>Pearl Higginson</u>	<u>Bancroft Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Pocatello Idaho</u>		BIRTHPLACE <u>Hatch Idaho</u>	
OCCUPATION <u>Mechanic</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at 5:20 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

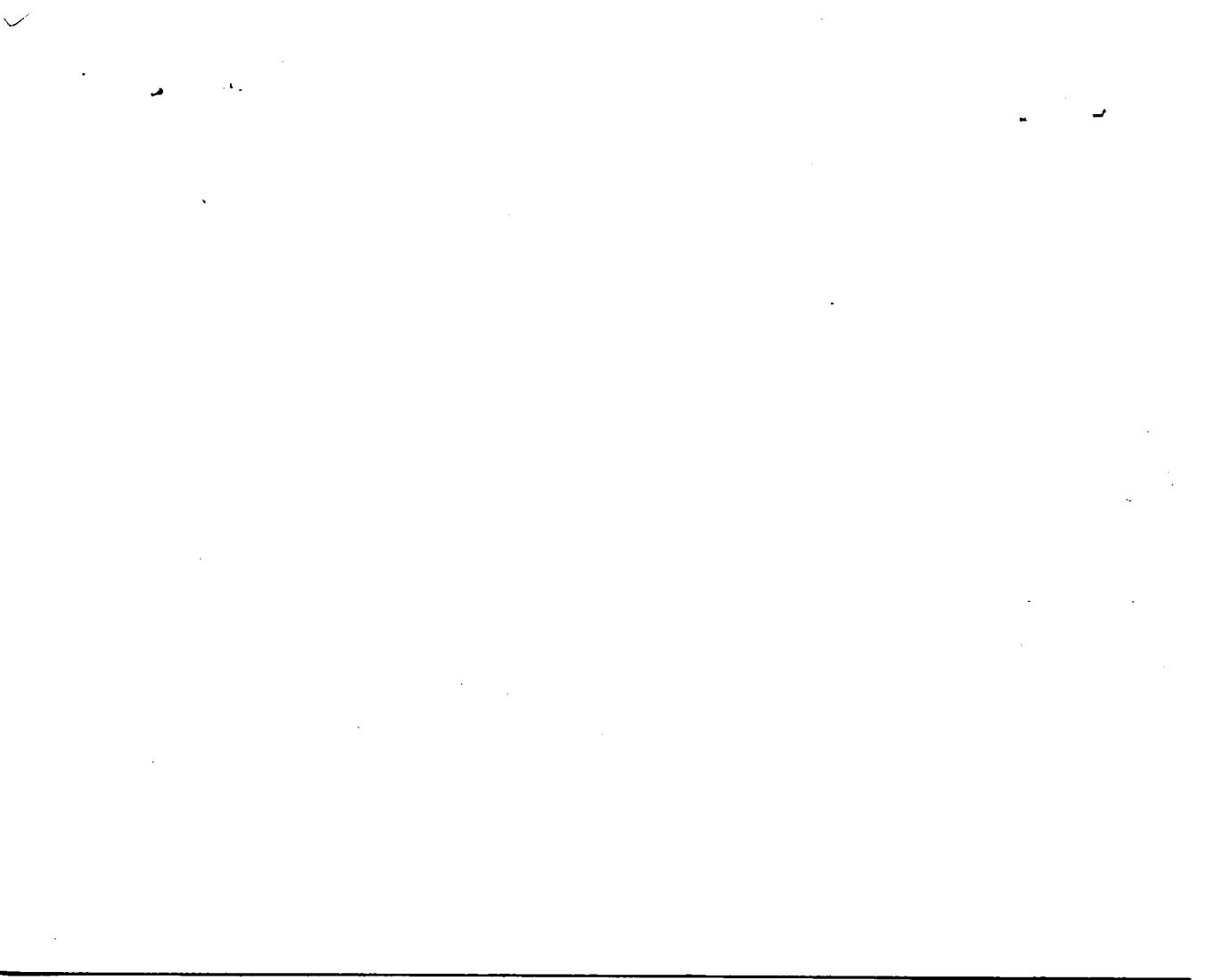
Give names added from a supplemental report.

(Signature) Chas. A. Rich

(Physician or midwife)

Address Lava Hot Springs

Filed 9/30- 1927 Mrs. W. J. Felt
Registrar.



RECEIVED OCT 11 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State-File No. 58807

- PLACE OF DEATH

County of Bannock
City of Lava Hot Springs

Registration District No. 84
Primary Registration District No. 2161

Local Registrar's No. 98

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence, No. Grant Lewis St. Bancroft Eden

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6. DATE OF BIRTH (month, day and year) Sept 28, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or
8th month of pregnancy Stillbirth gestation

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lava Hot Springs
(State or country) Idaho

10. NAME OF FATHER LeRoy Wilford Lewis

11. BIRTHPLACE OF FATHER (city or town) Pocatello
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Pearl Heggerson

13. BIRTHPLACE OF MOTHER (city or town) Nashua
(State or Country) Idaho

14. Informant B.A. Rich M.D. copied from birth certificate
(Address) Lava Hot Springs

15. Filed Oct - 2 - 1927 Mrs J. J. Fitch
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 28 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillbirth to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Unknown Cause
(Stillbirth)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

None known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) B.A. Rich M. D.

Sept 28, 1927 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

19

20. Undertaker

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

855-121-
PLACE OF BIRTH

003-799

RECEIVED SEP 20 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Swan Lake, Ida.

CERTIFICATE OF BIRTH 155005

No. _____ St. Registration District No. 23 State File No. _____

Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 21

FULL NAME OF CHILD Robert George Henderson

(Certificate of no value without full name of child)

Sex of Child Male Twin and { Number in order of birth 2nd Legitimate? yes Date of birth Aug-21-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol 20%

Number of child of this mother, including present birth 5th Number of child of this mother now living, including present birth 4

FULL NAME John Henderson
RESIDENCE Swan Lake, Idaho
COLOR white AGE AT LAST BIRTHDAY 33
(Years)
BIRTHPLACE Clifton, Idaho
OCCUPATION Farmer

FULL MAIDEN NAME Mable Boggs
RESIDENCE Swan Lake, Ida.
COLOR white AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Lawson, Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9 35 A.M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. J. Hartington, M.D.

(Physician or midwife)

Address Boone, Idaho

Filed Sept. 12-1927 Mary C. Coffin

Registrar.

Registrar.

RECEIVED BY THE BUREAU OF THE STATE DEPARTMENT OF HEALTH
 COUNTY OF ... CITY OF ...
 I hereby certify that I am within the birth and death room to issue an ...
 of the child to ... to ... and ...

The names of the ... from a ... report
 I have ... the ...
 I have ... the ...
 I have ... the ...
 I have ... the ...

on the date above stated.

I hereby certify that I am within the birth and death room to issue an ...

at ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION

BIRTHPLACE

COLOR

RESIDENCE

MOTHER

What particular condition was present at birth?

SEX OF CHILD

NAME OF CHILD

LEGAL NAME

CERTIFICATE OF BIRTH

DEPARTMENT OF HEALTH

STATE OF IDAHO

188
 1988

188
 1988

RECEIVED SEP 20 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Dawney

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83Primary Registration District No. 2160

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 58898Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Aug 21 1927
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Swan Lake, Ida.10. NAME OF FATHER Lester Henderson

11. BIRTHPLACE OF FATHER

(State or Country) Clifton, Idaho12. MAIDEN NAME OF MOTHER Millie Pratt

13. BIRTHPLACE OF MOTHER

(State or Country) Dawney, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lester Henderson(Address) Swan Lake, Idaho15. Filed Sept. - 12 - 1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw him _____ alive on Aug. 21 - 1927
and that death occurred on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Intrauterine Death
Macerated Fetus

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. P. Baskin M. D.(Address) Dawney, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Swan Lake, Idaho DATE OF BURIAL Aug. 22, 192720. UNDERTAKER None

ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238-128006-796
PLACE OF BIRTH

RECEIVED OCT 8 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Hamlet

CERTIFICATE OF BIRTH 55056

No. St. Registration District No. 121 State File No.

Hospital Primary Registration District No. 2194 Local Registrar's No. 324

FULL NAME OF CHILD

Baby Schell

(Certificate of no value without full name of child)

Sex of Child

m

Twin
Triplet
or other

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate

yes

Date of
birth

Aug 28 1927
(Month) (Day) (Year)

What bactericidal solution was used in eyes? 10% Mercurochrome

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Geo. M. Schell

RESIDENCE

R. 3 Shelly

COLOR

white

AGE AT LAST
BIRTHDAY 31
(Years)

BIRTHPLACE

Ohio

OCCUPATION

Lumber

FULL
MAIDEN
NAME

MOTHER

Louisa Jane Gifford

RESIDENCE

R. 3 Shelly

COLOR

white

AGE AT LAST
BIRTHDAY 22
(Years)

BIRTHPLACE

Idaho

OCCUPATION

House Keeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4 45 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Edwin Carter M.D.

(Physician or midwife)

Address

Shelly Ida

Filed

1927

Wm. Walter E. Galt

Registrar.

Registrar.

100

100

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 10 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Brigham
City of Woodville

Registration District No. 121
Primary Registration District No. 2194
(No. St.)

File No. 58551
Registered No. 728

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Schelff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the words)

6. DATE OF BIRTH

8 - 28 - 1927
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Woodville Ida

10. NAME OF FATHER

J. C. M. Schelff

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Louisa Jifford

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George M. Schelff
(Address) W. 3. Shelby

15. Filed Aug 29 1927 W. C. Waterhouse
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 - 28 - 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth
that I last saw him..... alive on.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Premature birth,
About 6 weeks gestation.
(Duration)..... yrs..... mos..... ds.

Contributory (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Edwin C. C. M. D.

8-28-1927 (Address) Shelby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodville County

8-29-1927

20. UNDERTAKER

ADDRESS

was employed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of

City of

No.

753-226-006-769

(If born in hospital or institution give name.)

FULL NAME OF CHILD

Sex of Child

Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
macy?

Date of
birth

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

(a) Born alive and now living

Born alive but now dead

Stillborn

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

Residence (Usual place of abode)

Residence (Usual place of abode)

If nonresident, give place and State

If nonresident, give place and State

Color or race

Age at last Birthday

Color or race

Age at last Birthday

Birthplace

(City and State or Country)

Birthplace

(City and State or Country)

Occupation

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~Born alive~~ Stillborn at 2:10 P. M. on the date above stated.

(Signature)

(Physician or midwife)

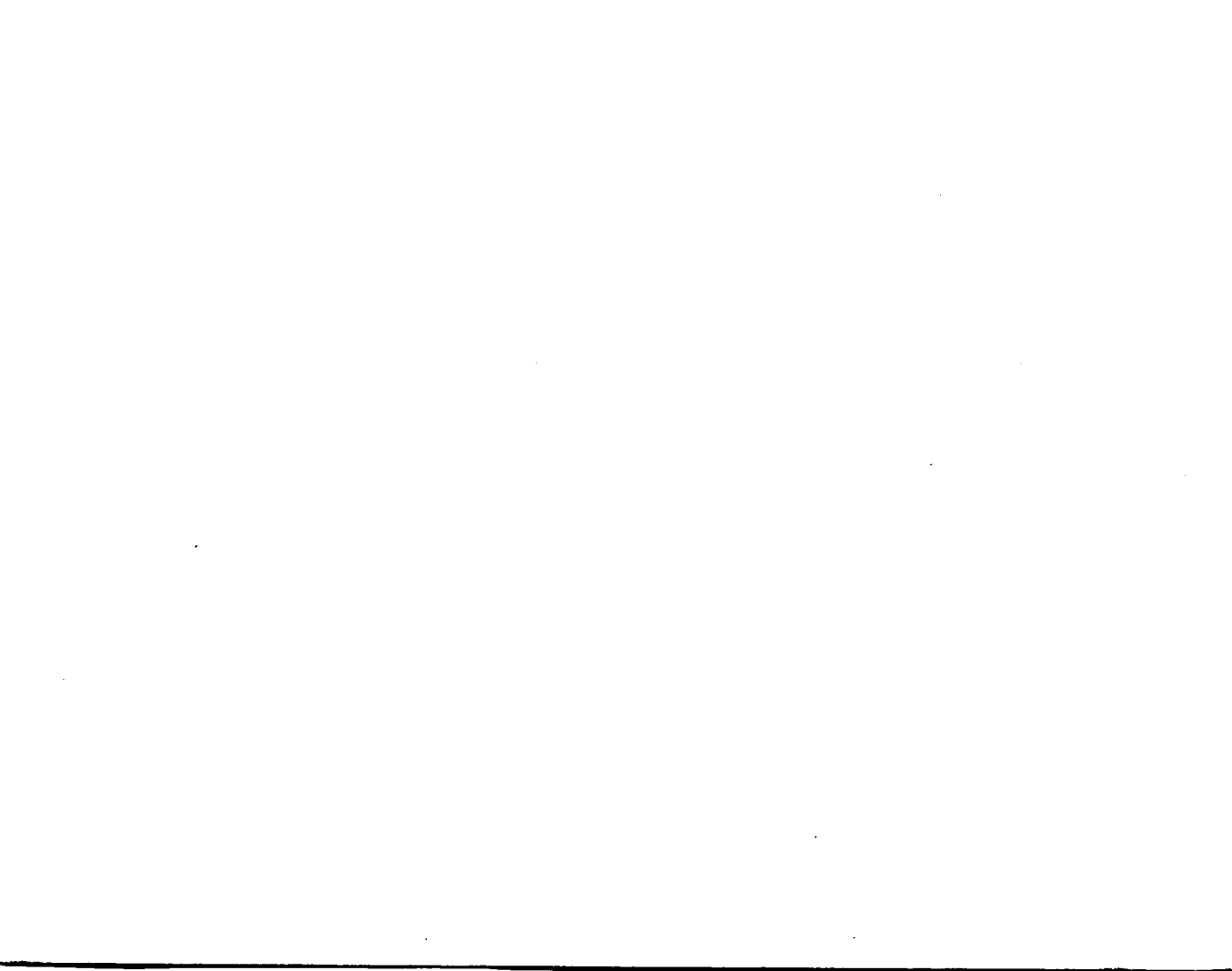
Address

Filed

2-10-27

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

925-229010-296

PLACE OF BIRTH

RECEIVED SEP 22 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Idaho Falls

No. 155133 Registration District No. 13 State File No. 155133

Hospital P. H. S. Primary Registration District No. 2145 Local Registrar's No. 311

FULL NAME OF CHILD Isenhour (Premature) Laura Elane
(Certificate of no value without full name of child)

Sex of Child F. Twin Triplet or other? } and { Number in order of birth 1 Legitimate? yes. Date of birth 7-29-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Clay Burton Isenhour
RESIDENCE 955 Park Ave.
COLOR White AGE AT LAST BIRTHDAY 40
(Years)
BIRTHPLACE Kansas
OCCUPATION Yard Foreman

MOTHER
FULL MAIDEN NAME Aline L. Brown
RESIDENCE 955 Park Ave.
COLOR White AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Kentucky
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 8:25 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Alice E. Davis
C. E. D.
(Physician or midwife)

Address Idaho Falls

Filed Aug 3 1927 Isenhour
Registrar. Registrar.

THIS CERTIFICATE IS A PART OF THE REGISTRATION OF BIRTHS AND DEATHS IN THE DISTRICT OF COLUMBIA, AND IS NOT VALID UNLESS IT IS SIGNED BY THE REGISTRAR.

STATE OF DISTRICT OF COLUMBIA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
City of _____
Hospital _____
Date of Birth _____

FULL NAME OF CHILD

Sex of Child _____

What bactericidal solution was used in case of infection?
To be filled in by the attending physician.

Month of Birth _____
Day of Birth _____
Year of Birth _____

Name of child of this mother, including present birth order.

MOTHER

FATHER

NAME _____
RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____

RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____

RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____

RESIDENCE _____
COLOR _____
AGE AT LAST BIRTHDAY _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the _____ above stated.

When there was no attending physician, I witnessed that the father, mother, or other person making this report, is a reliable person, and that the child is one that neither presents nor shows other evidence of illegitimacy.

(Give name added from a supplemental report)

1955
Registrar
Filed
1955
Rock Creek

MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 22 1927

PLACE OF DEATH

County of *Bourneil*
City of *Idaho Falls*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. *7-3*
Primary Registration District No. *2110*
(No. *R 10 S 1026*)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Infant Isenhour*

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *White*
5. Single, Married, Widowed, or Divorced (write the word) *Single*
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) *July 29-27*
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *no.*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) *Idaho Falls*
(State or country) _____
10. NAME OF FATHER *C. B. Isenhour*
11. BIRTHPLACE OF FATHER (city or town) *Idaho*
(State or Country) _____
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (city or town) *Idaho*
(State or Country) _____

14. Informant *C. B. Isenhour*
(Address) *Idaho Falls*

15. Filed *8/11*, 19*27* *W. J. Williams*
Registrar

DO NOT WRITE IN THIS SPACE

State File No. *58859*

Local Registrar's No. *101*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 29* 19*27*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

5 months for toxemia
(duration) yrs. mos. ds. *1 mos.*
CONTRIBUTORY *No cause for premature birth*
(Secondary) *discovered*
(duration) yrs. mos. ds.

18. Where was disease contracted _____
if not at place of death? ☒

Did an operation precede death? ☒ Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis *autopsy*
(Signed) _____, M. D.

_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Idaho Falls* Date of Burial *July 30 1927*

20. Undertaker *Chiffet House* Address *Idaho Falls*

268

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

549-115-010-619
PLACE OF BIRTH
County of Bannock RECEIVED SEP 25 1927
City of Idaho Falls
No. _____ St.
Registration District No. 73 State File No. _____
Prim. Registration District No. 214 Local Registrar's No. 297
FULL NAME OF CHILD George Robert Edie
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>July 15</u> 1927 (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Argyrol 5%

Number of child of this mother, including present birth 1 (a) Born alive and now living
Born alive but now dead _____ Stillborn 1

FATHER	MOTHER
FULL NAME <u>James H. Edie</u>	FULL MAIDEN NAME <u>Melba Waring</u>
Residence (Usual place of abode) <u>Idaho</u>	Residence (Usual place of abode) <u>Idaho</u>
If nonresident, give place and State <u>Idaho</u>	If nonresident, give place and State <u>Idaho</u>
Color or race <u>White</u> Age at last Birthday <u>23</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1205 A. M.
on the date above stated.

(Signature) H. J. Jensen

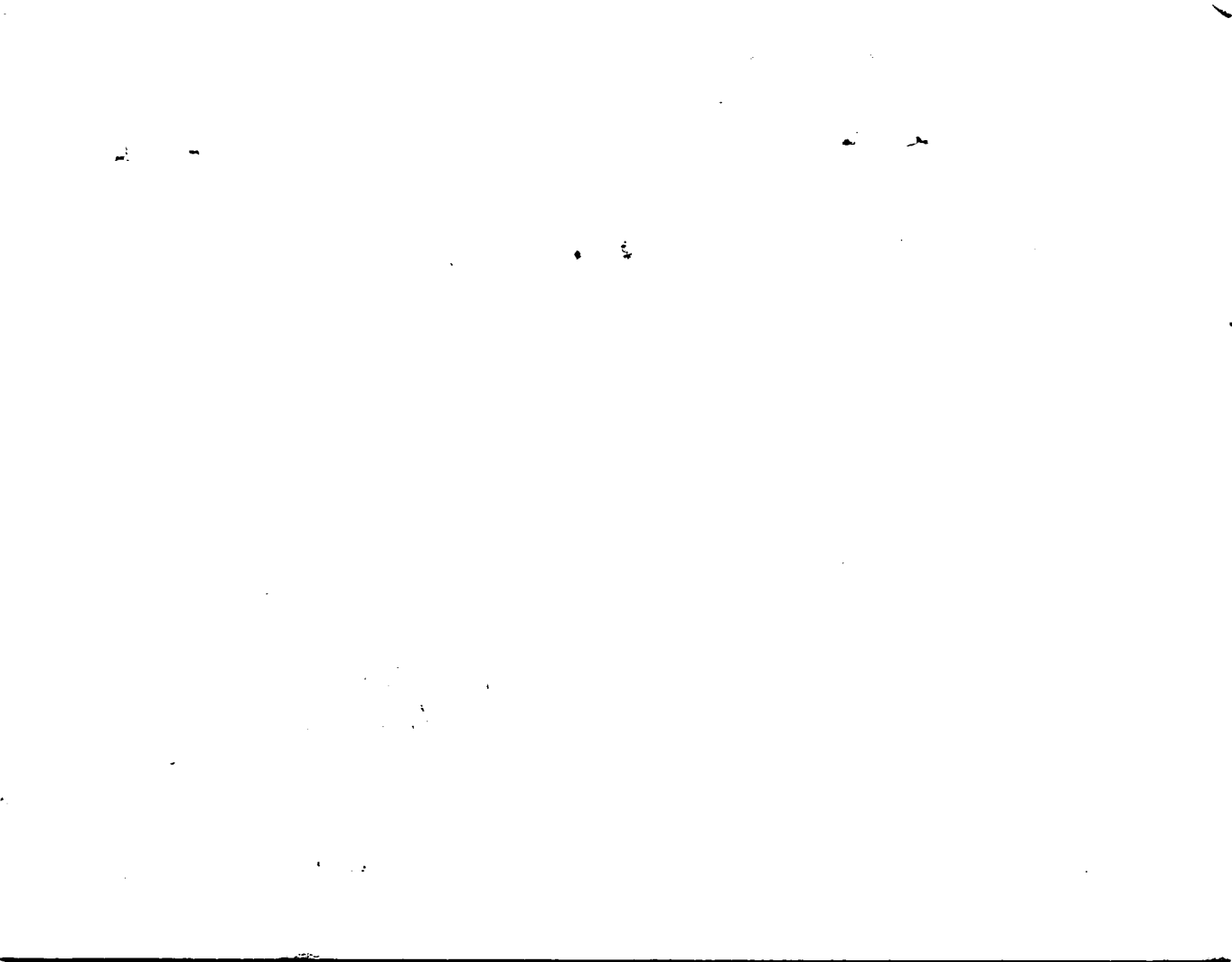
(Physician or midwife)

Address Idaho Falls, Ida

Filed Aug 1 1927 Conford

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 22 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

58844

State File No.

Local Registrar's No. 100

PLACE OF DEATH

County of Bonanza
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2145

(No. Spencer House)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant, Edie

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, min. Born dead

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls (State or country) Idaho

10. NAME OF FATHER James Edie

11. BIRTHPLACE OF FATHER (city or town) Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Melba Warming

13. BIRTHPLACE OF MOTHER (city or town) Idaho (State or Country)

14. Informant James Warming (Address) Embry's Hotel

15. Filed 2/3, 1927 W. Warming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1927, to , 1927

that I last saw him alive on , 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Warming M. D.

19. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Date of Burial July 15 1927

20. Undertaker Chaffey Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

249-277-011-846
PLACE OF BIRTH

RECEIVED OCT 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Bonner Ferry

CERTIFICATE OF BIRTH

155159

No. St. Registration District No. 79 State File No.

Hospital Primary Registration District No. 2156 Local Registrar's No.

FULL NAME OF CHILD Baby Buraker

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and {	Number in order of birth <input checked="" type="checkbox"/>	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept. 27, 1927</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Harold Buraker</u>	<u>Bonner Ferry</u>	<u>Fay Huffman</u>	<u>Bonner Ferry</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Wash.</u>		BIRTHPLACE <u>Texas</u>	
OCCUPATION <u>Electrician</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. E. J. J.

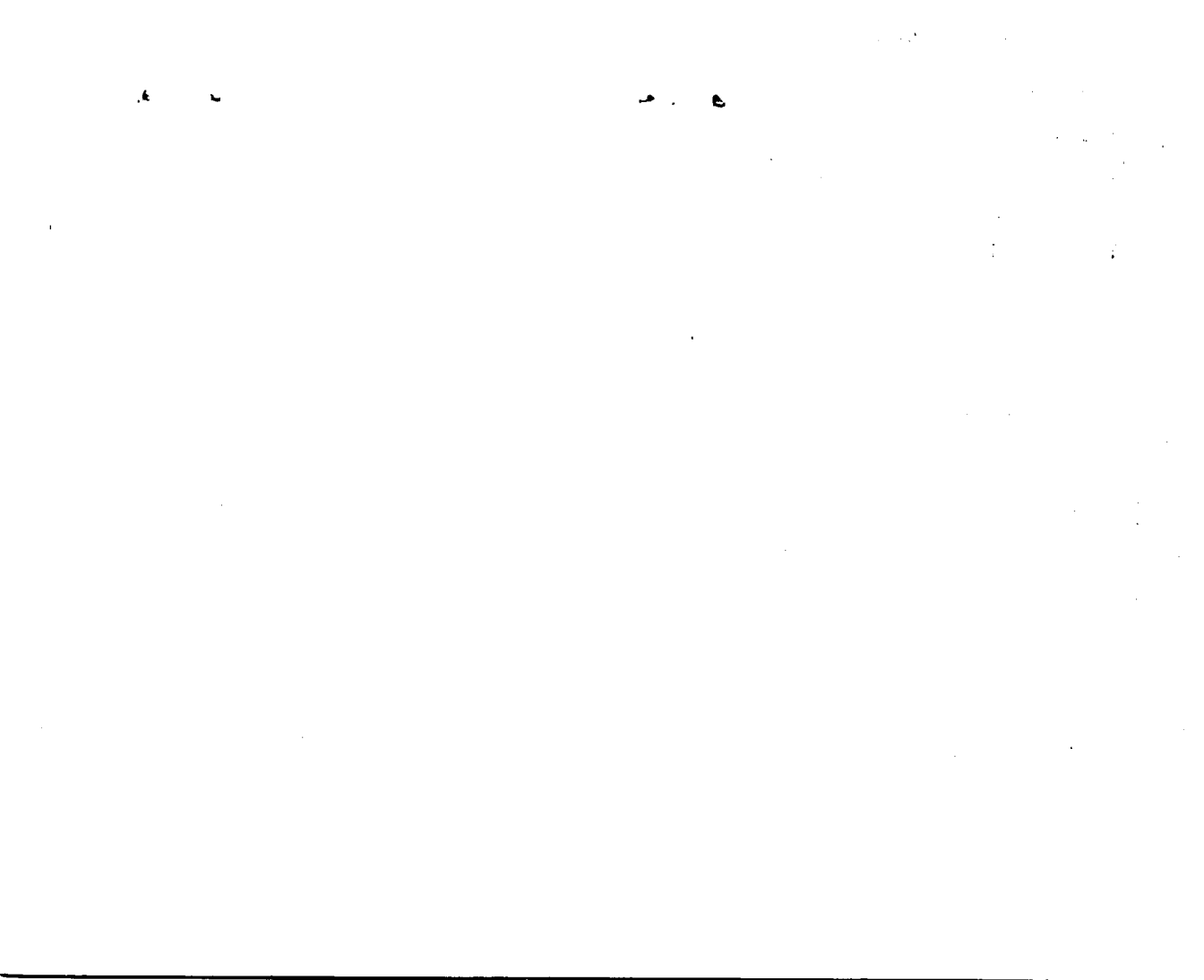
(Physician or midwife)

Address Bonner Ferry, Id.

Filed 9/30/1927

Registrar.

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 58874

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Boundary Registration District No. 19
City of Bonners Ferry Primary Registration District No. 215 Local Registrar's No. _____
(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Burrocker

(a) Residence. No. _____ St. _____

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 27-27

7 AGE Years Months Days Stillborn If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bonners Ferry
(State or country)

10 NAME OF FATHER H. Burrocker

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country)

12 MAIDEN NAME OF MOTHER Lay Huffam

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant H. Burrocker
(Address) Bonners Ferry, Ida

15 Filed 9/27, 1927 Registrar E. E. Hays

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 27th 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
(Death in utero)

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Dissection of skin

(Signed) E. E. Hays, M. D.

9/27/1927 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Bonners Ferry, Ida Date of Burial Sept 28 1927

20. Undertaker H. R. Crouch, Bonners Ferry Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A
N. B.—In case of more than one child at birth a SEPARATE form must be used.
115-257 each and the number of each, in order of birth stated.

212-222-074-569
PLACE OF BIRTH

RECEIVED OCT 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Nampa

No. _____ St. _____

Registration District No. _____

State File No. _____

155178

Hospital Nazarene

Primary Registration District No. 1006

Local Registrar's No. 467

FULL NAME OF CHILD

Infant Baser

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Sept. 22

1927

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Argyrol

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 5

FULL
MAIDEN
NAME

FATHER

Henry Clayton Baser

RESIDENCE

Nampa, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Clara Woodward Baser

RESIDENCE

Nampa Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

35
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____ A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

1927

Registrar.

(Signature)

Geo R Proctor
physician
(Physician or midwife)

Address

Nampa Ida

Filed

10-6

1927

Mac Kerby

Registrar.

NOT RECORDED

ND

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

235711-014-619

PLACE OF BIRTH

County of Canyon
City of Caldwell
No. _____ St. _____

Caldwell Sanitarium
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

155200

Registration District No. _____ State File No. _____

Prim. Registration District No. 2005 Local Registrar's No. 115

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>8/11</u>	<u>27</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 11 (a) Born alive and now living 9
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Frank Steelman
Residence (Usual place of abode) Rt. 4 Caldwell, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 46
Birthplace Virginia (Years)
(City and State or Country)
Occupation Farming

MOTHER
FULL MAIDEN NAME Nancy Ward
Residence (Usual place of abode) Rt. #4 Caldwell, Idaho
If nonresident, give place and State _____
Color or race white Age at last Birthday 41
Birthplace Washington (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 6:07 P. M.
on the date above stated.

(Signature) S. E. Dudley

M. D.
(Physician or midwife)

Address Caldwell Idaho

Filed 8-12-1927 John H. Meyer
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

12-19

CONFIDENTIAL

1944

- Nigel
 - Robert

What prophylactic was used to prevent Ophthalmia Neonatorum?

459-002

MSU
AMAR

18. On the other hand, the following is a possible explanation:

DATE: 11-11-2011

(continued on other side)

RECEIVED AT THE OFFICE OF THE DIRECTOR OF NATIONAL INTELLIGENCE

It is hereby certified that I attended the birth of this child, who was born on 2/10/1947.

11-21-5

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 20 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58901

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2009

Local Registrar's No. 84

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Steelman

(a) Residence. No. Caldwell, Idaho R # 4 St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 11, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

10. NAME OF FATHER Frank Steelman

11. BIRTHPLACE OF FATHER (city or town) Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Nancy Ward

13. BIRTHPLACE OF MOTHER (city or town) Washington
(State or Country)

14. Informant Frank Steelman
(Address) Caldwell, Idaho R # 4

15. Filed 8-12- 1927 John B. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Undetermined
Aug (Month) 1-11 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on Steel Born 8-11- 1927
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Undetermined

(duration) yrs. mos. 10-12 ds.

CONTRIBUTORY Undetermined
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) SOB Dyerley, M. D.

8-12- 1927 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill Date of Burial Aug 12 1927

20. Undertaker C. V. Peckham Address Caldwell, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

291-128-019-249
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED SEP 18 1927
County of Custer

City of Challis

CERTIFICATE OF BIRTH 155237

No. St. Registration District No. 108 State File No.

Hospital Primary Registration District No. 2186 Local Registrar's No. 133

FULL NAME OF CHILD Unnamed

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth Aug 28 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Lloyd Metcalf Bradbury

RESIDENCE Idaho

COLOR White AGE AT LAST BIRTHDAY 34 (Years)

BIRTHPLACE Idaho

OCCUPATION Ranching

MOTHER
FULL MAIDEN NAME Violet Marie Smith

RESIDENCE Idaho

COLOR White AGE AT LAST BIRTHDAY 33 (Years)

BIRTHPLACE Minnesota

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. B. Kirkley M.D.

(Physician or midwife)

Address

File Aug 31 1927 Edna M. Kenney

Registrar.

Registrar.

REPORT MADE IN 1969 TO COMMISSIONERS OF THE

HTXIB 90 37A.14

DEPARTMENT OF JUSTICE
BUREAU OF PRISON STATISTICS
WASHINGTON, D. C.

CONTRIBUTOR OF BRITAIN

Country of _____

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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Number of child of this mother now living (not including birth

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DATE
BIRTHDAY

2019年10月17日

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CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

On the date of the above mentioned meeting, I hereby certify that the above mentioned information is true and correct.

When there was an attending physician
or physician in the field, a
set should be the better of the
field is not the better of the
field is not the better of the

1. Foreign intelligence is used to the maximum extent possible to

(b) (5) - (D)

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Resistant

• 7573 2124-11

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58921

County of CusterRegistration District No. 108City of ChallisPrimary Registration District No. 2186Local Registrar's No. 65(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Not named

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug 28, 19277. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Challis, Ida
(State or country)

10. NAME OF FATHER

Floyd Metcalf Bradbury11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Violet Marie Smith13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Idaho14. Informant Violet Marie Smith
(Address) Challis, Idaho15. Filed Aug 31, 1927 Clin M. Kenney
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 28, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 28, 1927, to Aug 28, 1927
that I last saw him on Aug 28, 1927
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Born at 5 months gestation Cause
not known

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) C. B. Kistley M. D.
Aug 31, 1927 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Challis, Ida Aug 28, 1927

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as **fractured skull, and consequences** (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

919-116-025-494
PLACE OF BIRTH

RECEIVED OCT 10 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho

City of Cottonwood

CERTIFICATE OF BIRTH

155310

No. _____ St. _____ Registration District No. 105 State File No. _____

Hospital _____ Primary Registration District No. 2183 Local Registrar's No. 70

FULL NAME OF CHILD

Stilleen

(Certificate of no value without full name of child)

Sex of
Child

male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

9-16-

1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes? ~

Number of child of this mother, including present birth 11

Number of child of this mother now living, including present birth 8

FULL
NAME

FATHER

R. R. Raming

RESIDENCE

Cottonwood

COLOR

W

AGE AT LAST

BIRTHDAY

39

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Nettie Raming

RESIDENCE

Cottonwood

COLOR

W

AGE AT LAST

BIRTHDAY

41

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~Born alive~~ } Stillborn at 6:30 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

G. A. Woodcock, M.D.

(Physician or midwife)

Address

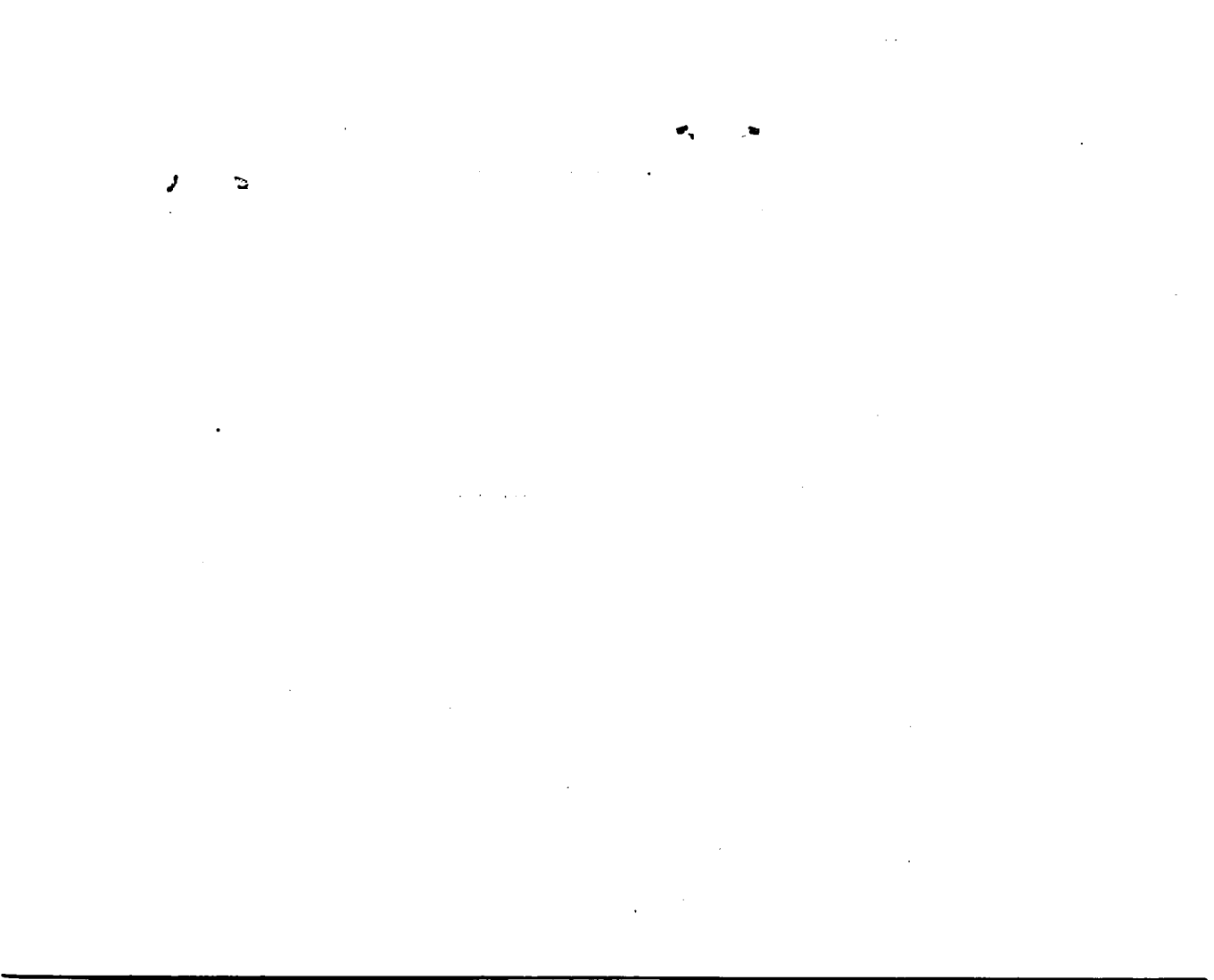
Cottonwood, Idaho

Filed

Oct-1 1927

H. J. Cropper, S. B.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 10 1927

CERTIFICATE OF DEATH

58942

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

File No. 15

City of Cottonwood

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Steele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

9-16-1927
(Month) (Day) (Year)

7. AGE

Steele

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Cottonwood Idaho

10. NAME OF FATHER

R. R. Raming

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Nettie Dunsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R. R. Raming

(Address)

Cottonwood

15.

Filed

Oct. 1 1927 H. J. O'Connell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Steele

9-16-1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. A. Woodcock M. D.

9-16-1927 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cottonwood

DATE OF BURIAL

9-16-1927

20. UNDERTAKER

R. R. Raming Cottonwood, Ida.

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

142

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

493-210-031-619
PLACE OF BIRTH

RECEIVED OCT 6 - 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewis
City of Craigmont RFD

CERTIFICATE OF BIRTH -

No. _____ St. _____ Registration District No. 50 State File No. 155429
Hospital _____ Primary Registration District No. 2129 Local Registrar's No. 48

FULL NAME OF CHILD Still born Mitchell Mardell
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	<u>Twin</u> Triplet or other? <u>Yes</u>	and { <u>2</u> } Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept 10</u> <u>1927</u> (Month) (Day) (Year)
----------------------------	---	--	--------------------------	--

What bactericidal solution was used in eyes? 1% AgNO3
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Madison Leroy Mitchell
RESIDENCE Craigmont RFD
COLOR white AGE AT LAST BIRTHDAY 26
(Years)
BIRTHPLACE Nezperce Idaho
OCCUPATION Trucker

MOTHER
FULL MAIDEN NAME Ellis Ward
RESIDENCE Craigmont RFD
COLOR white AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Ido
OCCUPATION Housewife

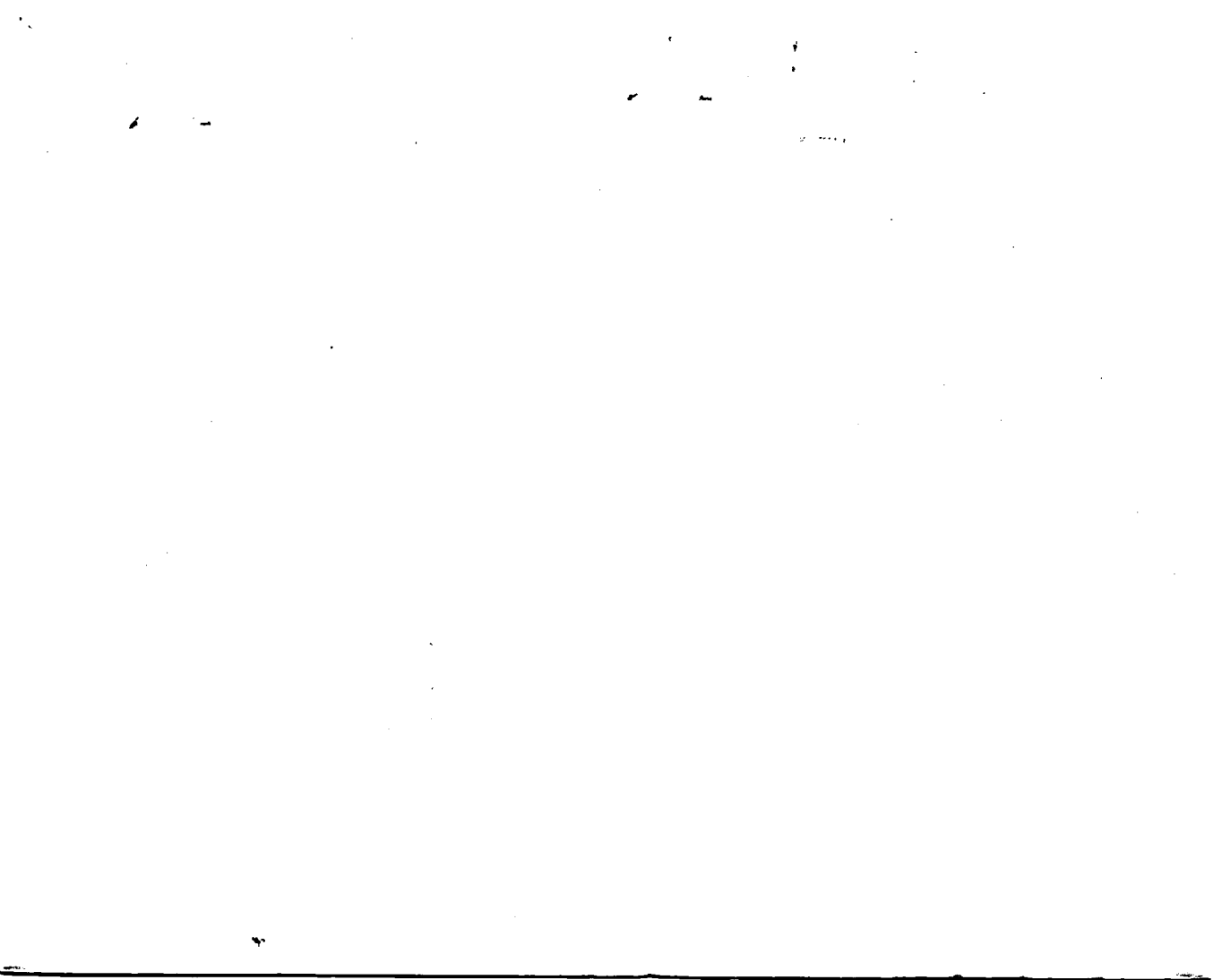
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 12.25 P M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) P. E. Dwyer
(Physician or midwife)

Address Craigmont Idaho
Filed 9-10 1927
Registrar. P. E. Dwyer Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 6 - 1927
OFFICE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58996

Local Registrar's No. 15

County of Lewis
City of Craigmont RFD

Registration District No. 50
Primary Registration District No. 2129
(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female
4 COLOR OR RACE white
5 Single, Married, Widowed, or Divorced (write the word) --

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)
Craigmont Idaho RFD

10 NAME OF FATHER

Madison Leroy Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country)
Nezperce Idaho

12 MAIDEN NAME OF MOTHER

Ellie E Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country)
MO

14 Informant M L Mitchell
(Address) Craigmont RFD

15 Filed 9-10 27
19

R E Dwyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 27
Sept 10 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927, to Sept 10, 1927, that I last saw her alive on ---, 19---, and that death occurred, on the date stated above, at --- m. The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R E Dwyer 9-10 27 (Address) Craigmont Idaho RFD

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
Nezperce Idaho 9-11-1927

20 Undertaker M L Mitchell
Craigmont RFD

14

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

335-117-026-443
PLACE OF BIRTH
County of Jefferson STATE OF IDAHO
City of Rigby DEPT. OF PUBLIC WELFARE
No. _____ OF VITAL STATISTICS
Registration District No. 100 State File No. 155457
Prim. Registration District No. 2178 Local Registrar's No. 185
(If born in hospital or institution give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twins <u>✓</u> Triplet or other? <u>✓</u> (To be answered only in event of plural births)	and {	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Aug 17</u> 19 <u>27</u> (Month) (Day) (Year)
--------------------------	---	-------	-----------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 3 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 2

FATHER
FULL NAME Lawrence Clement
Residence (Usual place of abode) Rigby
If nonresident, give place and State —
Color or race W Age at last Birthday 32 (Years)
Birthplace Ida. (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Vera Murchie
Residence (Usual place of abode) Rigby
If nonresident, give place and State —
Color or race W Age at last Birthday 20 (Years)
Birthplace Ida. (City and State or Country)
Occupation —

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10:25 P M.
on the date above stated.

(Signature) H. B. Rigby MD

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 9-9 1927

Registrar W. E. Smith



NP

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

335-117.026-495
PLACE OF BIRTH

County of Jefferson
City of Highway
No. St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 100 State File No. 155458
Prim. Registration District No. 2178 Local Registrar's No. 184

S

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and {	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Aug 17</u> 19 <u>27</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 2
Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Lawrence Clements
Residence (Usual place of abode) Highway
If nonresident, give place and State
Color or race W Age at last Birthday 32 (Years)
Birthplace Hubbard Ida (City and State or Country)
Occupation farmer

MOTHER
FULL MAIDEN NAME Vera Minghie
Residence (Usual place of abode) Highway
If nonresident, give place and State
Color or race W Age at last Birthday 20 (Years)
Birthplace Ida (City and State or Country)
Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. Highway Ida M.

(Signature) Highway
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address
Filed 9-9 1927 Highway Registrar.

7/1/77

62

1/1

NO

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

296-214042-285
PLACE OF BIRTH

County of Twin Falls
City of Kimberly
No. _____ St.

home

(If born in hospital or institution
give name.)

RECEIVED OCT 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Registration District No. 36 State File No. 155633

Prim. Registration District No. _____ Local Registrar's No. 60

"Stillbirth".

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth	<u>Sept. 14,</u>	<u>19 27</u>
<u>female</u>				(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Vance P. Brown

Residence (Usual place of abode) Kimberly, Idaho.

If nonresident, give place and State _____

Color or race white Age at last Birthday 42

(Years)

Birthplace Tennessee

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Bessie Savage

Residence (Usual place of abode) Kimberly, Idaho.

If nonresident, give place and State _____

Color or race white Age at last Birthday 40

(Years)

Birthplace Tennessee

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 : _____ P. M.
on the date above stated.

(Signature) J. N. Davis, M.D.

Physician

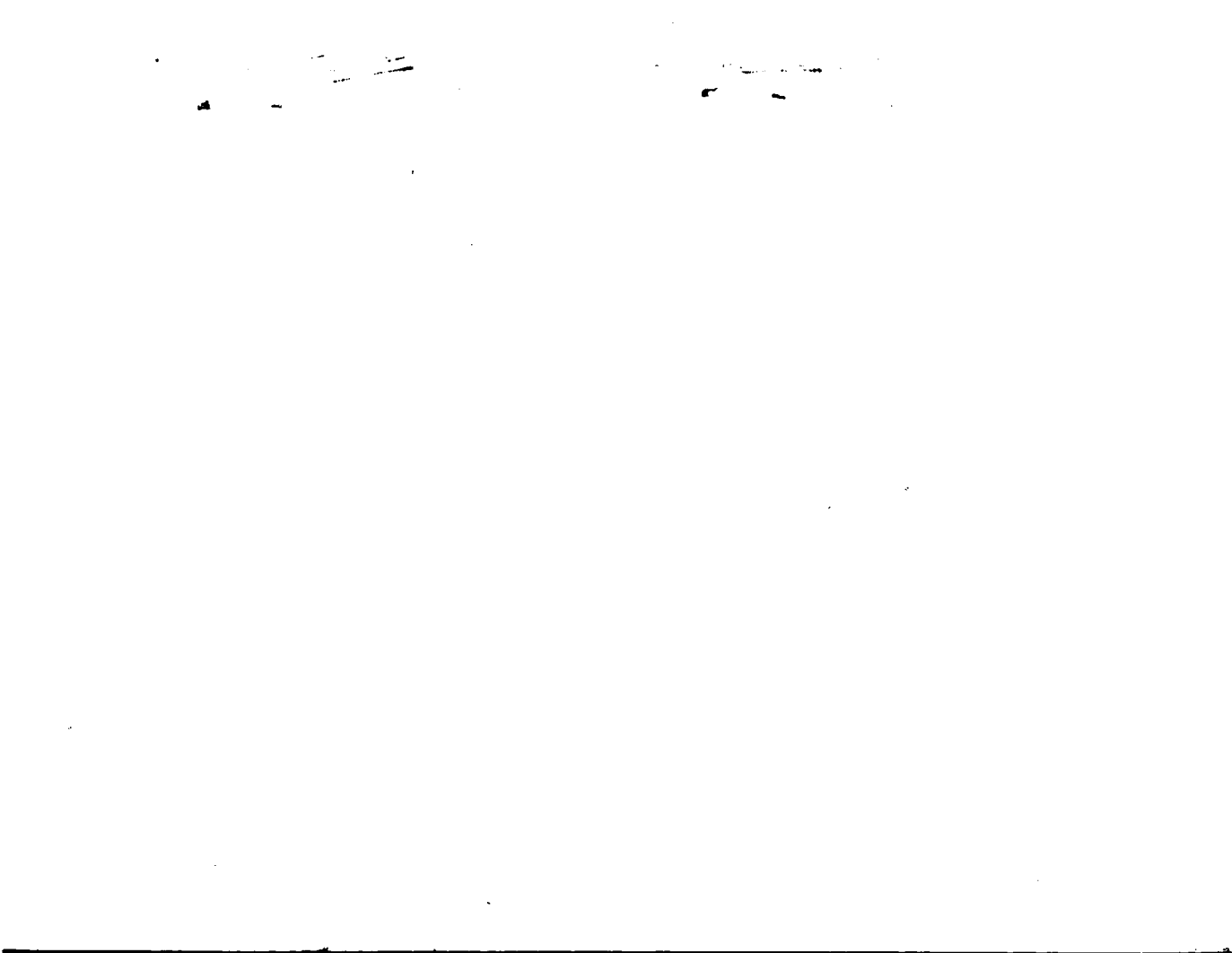
(Physician or midwife)

Address Kimberly, Idaho.

Filed Sept. 20 1927

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Twin Falls,
City of Kimberly,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (unnamed) Brown "Stillbirth"

CERTIFICATE OF DEATH

Registration District No. 36
Primary Registration District No. _____
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 59080
Local Registrar's No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED _____

(Write the word)

6. DATE OF BIRTH

Sept. 14, 1927
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
_____ hrs. or
_____ min.?
0 Yrs. 0 Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work 0
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Kimberly, Idaho.

10. NAME OF Father

Vance P. Brown,

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER

Bessie Savage

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vance P. Brown
(Address) Kimberly, Idaho

15.

Filed Sept. 20, 1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 14, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1927, to Sept. 14, 1927, that I last saw h. "Stillbirth" 1927, and that death occurred on the date stated above, at 11, P. M.

The CAUSE OF DEATH* was as follows:

Not determined,

Probably been dead over a week

8 months gestation. Wt. 5½ #

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. N. Davis M. D.
Sept 20 1927 (Address) Kimberly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

cremated

DATE OF BURIAL

Sept. 21 192720. UNDERTAKER none

ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

County of Twin FallsCity of Twin FallsNo. 866105042929 St.Hospital CountyRegistration District No. 37 State File No.Primary Registration District No. 1085 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth } Legiti- mate? yes Date of birth 9/5 1927
(To be answered only in event of plural births) (Month) (Day) (Year)What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2FULL NAME FATHER Harold Christman HowellFULL MAIDEN NAME MOTHER Rose Hulda ZbindenRESIDENCE T.F.RESIDENCE T.F.COLOR W AGE AT LAST BIRTHDAY 26 (Years)COLOR W AGE AT LAST BIRTHDAY 28 (Years)BIRTHPLACE OhioBIRTHPLACE GermanyOCCUPATION mail carrierOCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 4:10 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) C. J. Weaver

(Physician or midwife)

Address T.F.Filed 10-10 1927 John F. Coughlin

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



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RECEIVED SEP 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 58744

PLACE OF DEATH

County of *San Jales*City of *San Jales*Registration District No. *37*Primary Registration District No. *19 & 5*Local Registrar's No. *100-*(No. *Co. General Hosp.*)

(If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. *536 - 5th Ave E* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

*Single*5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14.

Informant
(Address)

15.

Filed *7-10*19*27**John F. Connelley*
Registrar

MEDICAL CERTIFICATE OF DEATH

18. DATE OF DEATH

Sept 6

(Month)

(Day)

19*27*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Sept. 6, 1927, to*that I last saw him alive on *fore dead*, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Dislocated placenta.

(duration) _____ yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *L. D. Weaver*, M. D.19 _____ (Address) *T. J.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Logan Utah

19

20. Undertaker

Address

*J. E. Drake**J. J.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED OCT 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Twin Falls

CERTIFICATE OF BIRTH

No. 651 229 042 819 St. Registration District No. 37 State File No. 155648

Hospital _____ Primary Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Louise Cornelia Weatherby
(Certificate of no value without full name of child)

Sex of Child 7 Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate Yes Date of birth Sept 29 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Thos. A Weatherby
RESIDENCE Hazelton
COLOR white AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE Wash
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Emma Haigler
RESIDENCE Hazelton
COLOR wh AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE So. Car.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 3 30 a M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1927

Registrar.

(Signature)

Ed Barry
Hazelton Ida
(Physician or midwife)

Address _____

Filed 10-10 1927

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 9 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59398

PLACE OF DEATH
County of Lincoln
City of " "

Registration District No. 37

Primary Registration District No. 185

Local Registrar's No. 122

(No. As per Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louise Cornelia Weatherby

(a) Residence. No. Stagelton St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 29 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ida. (State or country)

10. NAME OF FATHER T. A. Weatherby

11. BIRTHPLACE OF FATHER (city or town) Washington (State or Country)

12. MAIDEN NAME OF MOTHER Anna Hailor

13. BIRTHPLACE OF MOTHER (city or town) Sp. Carolina (State or Country)

14. Informant T. A. Weatherby (Address) Stagelton Ida

15. Filled 11-10 1927 John H. Long Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 25 Sept. 29 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
marital dystocia and premature separation of placenta
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) E. H. Berry M.D.
Sept 30 1927 (Address) Stagelton Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Inter 200 ft. Date of Burial Sept 30 1927

20. Undertaker P. J. Grossman Address Lincoln

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

DAHO
County DEPARTMENT OF PUBLIC WELFARE
City of Council Bluffs BUREAU OF VITAL STATISTICS
No. 957 716 002 653 St. CERTIFICATE OF BIRTH **S**
(If born in hospital or institution
give name.) Registration District No. State File No. 155741
Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD Danard Ingram
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 16 1927</u> (Month) (Day) (Year)
--------------------------	---	--	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Celta Ingram</u>	FULL MAIDEN NAME <u>Mary Welch</u>		
Residence (Usual place of abode) <u>Council Bluffs</u>	Residence (Usual place of abode) <u>Council Bluffs</u>		
If nonresident, give place and State <u> </u>	If nonresident, give place and State <u> </u>		
Color or race <u>white</u> Age at last Birthday <u>29</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>28</u> (Years)		
Birthplace <u>Mo</u> (City and State or Country)	Birthplace <u>Va</u> (City and State or Country)		
Occupation <u>Laborer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was {
Born alive
Stillborn } at 11 A. M.
on the date above stated.

(Signature) D. O. Hagg
M. D.
(Physician or midwife)

Address Council Bluffs
Filed 8/17 1927 W. M. Brown
Registrar.

{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }



11/1/55

11/1/55

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 18 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 59133

1. PLACE OF DEATH
County of Adams
City of Council
Registration District No.
Primary Registration District No.
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Ingram

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

16. DATE OF DEATH Aug 16 1927
(Month) (Day) (Year)

6. DATE OF BIRTH Aug 16 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 1927 and that death occurred on the date stated above, at M.

7. AGE 70 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH* was as follows:
Hydrocephalus

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

(Duration) Yrs. mos. ds.

9. BIRTHPLACE
(State or Country) Council Ida

Contributory (Secondary)

10. NAME OF FATHER Alta Ingram

(Duration) yrs. mos. ds.

11. BIRTHPLACE OF FATHER Ida
(State or Country) Va.

(Signed) D. P. Hipp M. D.

12. MAIDEN NAME OF MOTHER Mary Wilder

Aug. 17, 1927. (Address) Council Ida

13. BIRTHPLACE OF MOTHER Va
(State or Country)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alta Ingram
(Address) Council Ida

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

15. Filed Oct 17 1927 J. H. Ingram
Local Registrar

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Council Ida DATE OF BURIAL Aug 16 1927

20. UNDERTAKER E. Fisher ADDRESS Council Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

366-229 006815
PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. Shelby & Town St.

RECEIVED NOV 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

155810

Registration District No. 124 State File No.

Prim. Registration District No. 1007 Local Registrar's No. 374

FULL NAME OF CHILD Muriel Cook

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>10</u> <u>29</u> <u>1927</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 2 (a) Born alive and now living —

Born alive but now dead — Stillborn Yes

FATHER
FULL NAME John Ray Cook
Residence (Usual place of abode) Blackfoot, Ida R.D. 2
If nonresident, give place and State
Color or race Caucasian Age at last Birthday 26
Birthplace Utah (Years)
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Helen Theresa Hansen
Residence (Usual place of abode) Blackfoot, R.D. 2
If nonresident, give place and State
Color or race Caucasian Age at last Birthday 24
Birthplace Idaho (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

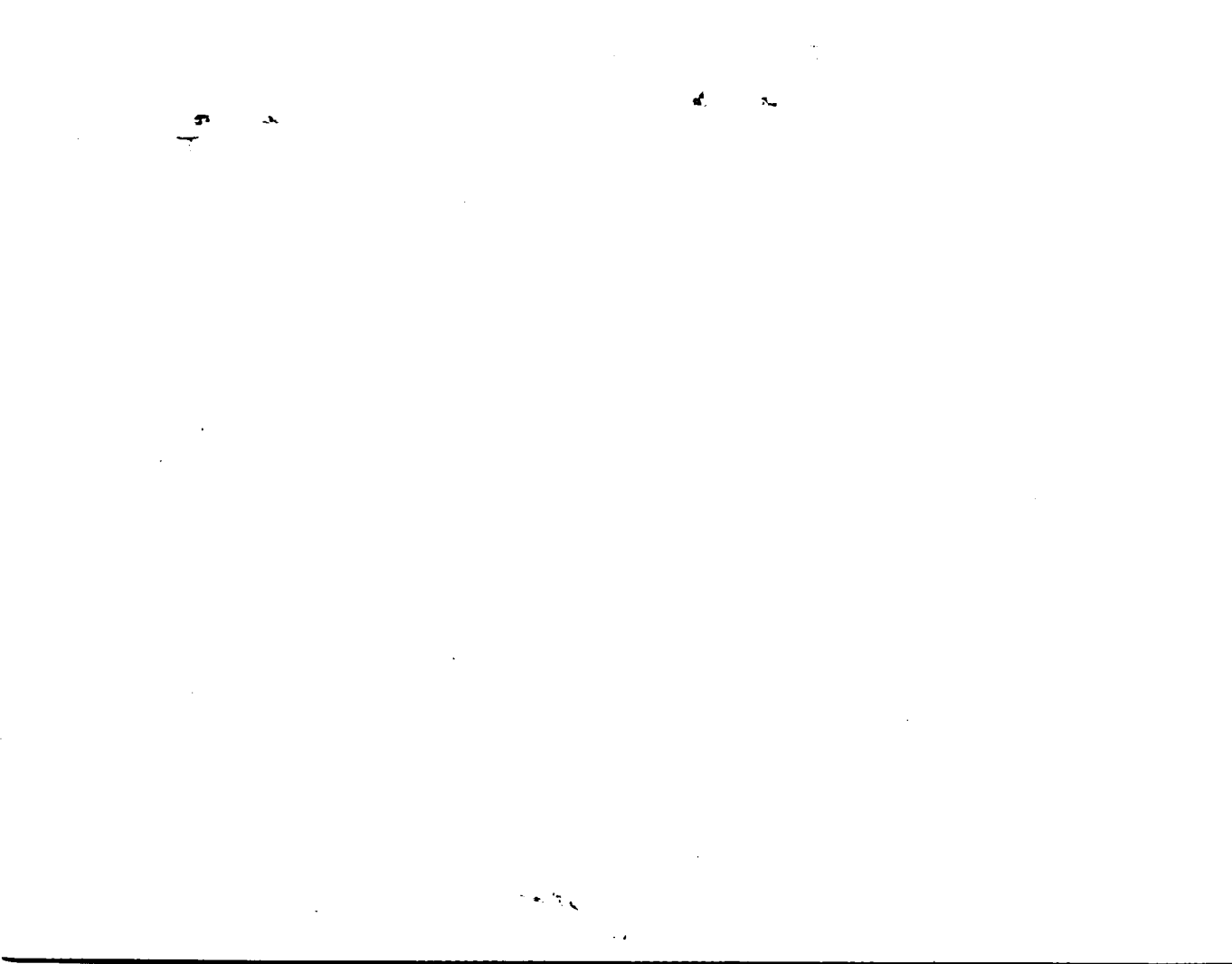
I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12 PM on the date above stated.

(Signature) E. H. Brown M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Holkins Building Blackfoot, Ida

Filed Nov 9 1927 Mr. Charles E. Volney
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25, M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 131Primary Registration District No. 1007

(No. _____ St.)

Wm.amed CookSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 59166Local Registrar's No. 1007

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

10

(Month)

29

(Day)

1927

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many

hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Blackfoot, Ida

10. NAME OF FATHER

John Ray Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Hazel Theresa Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. E. Hansen
Blackfoot

15.

Filed

Oct 29

19

Wm.amed Cook

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10

(Month)

29

(Day)

1927

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

not at all

19

that I last saw her alive on not at all 19and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Protracted labor necessitating use of instrument, D & W. C.
Patience Blackfoot, Ida, was consultant and present at said delivery.

Conjunctive (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

10.29.27 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot, Ida Oct 29 1927

ADDRESS Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDE**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 10 1927

STATE OF IDAHO

County of Blaine

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Blackfoot

CERTIFICATE OF BIRTH **S** 155836

No. 23 N. Blaine St.

493-209006366

Registration District No. 121 State File No. _____

(If born in hospital or institution give name.)

Prim. Registration District No. 1007 Local Registrar's No. 360

FULL NAME OF CHILD Unnamed Miller

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>Oct 9th 1927</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Will R. Miller</u>	MOTHER FULL MAIDEN NAME <u>Nettie May Cook</u>
---	---

Residence (Usual place of abode) Blackfoot Ida Id

If nonresident, give place and State _____

Color or race White Age at last Birthday 22 Color or race White Age at last Birthday 20
(Years) (Years)

Birthplace Utah (City and State or Country) Birthplace Idaho (City and State or Country)

Occupation Bus man Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Blackfoot on the date above stated. 2:4 M.

(Signature) M. E. Schrie

(Physician or midwife)

Address Blackfoot Idaho

Filed Oct 9 1927 M. E. Schrie Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59158

Local Registrar's No. 460

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed Miller(a) Residence. No. 23 N. Walling Ave. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. Age 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 9, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot Idaho
(State or country)10. NAME OF FATHER Will K. Miller11. BIRTHPLACE OF FATHER (city or town) Providence
(State or Country) Utah12. MAIDEN NAME OF MOTHER Matie May Cook13. BIRTHPLACE OF MOTHER (city or town) Providence
(State or Country) Idaho14. Informant Will K. Miller
(Address) Blackfoot Idaho15. Filed Oct 9, 1927 W. B. Daprie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9, 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1927, to Oct 9, 1927
that I last saw him alive on Oct 9, 1927
and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:
Still born 5 months
due to accident to
mother
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) W. B. Daprie M. D.Oct 9, 1927 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Town north Blackfoot Date of Burial Oct 9, 1927

20. Undertaker Will K. Miller Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED OCT 22 1927

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of *Bennettsville*City of *Ida Falls*

CERTIFICATE OF BIRTH

No. *595-220-010962*Registration District No. *73*State File No. *155901*Hospital *no*Primary Registration District No. *1140*Local Registrar's No. *374*

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

*Female*Twin
Triplet
or other? *x*

and {

Number
in order
of birth *x*

{

Legiti-
mate? *yes*Date of
birth *9 20 1927*

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *3*Number of child of this mother now living, including present birth *1*FULL
NAME

FATHER

Edgar Nelson

RESIDENCE

Ida Falls

COLOR

W.

AGE AT LAST

BIRTHDAY *28*

(Years)

BIRTHPLACE

Ida Falls

OCCUPATION

*Labour*FULL
MAIDEN
NAME

MOTHER

Angel Ross

RESIDENCE

Ida Falls

COLOR

W.

AGE AT LAST

BIRTHDAY *23*

(Years)

BIRTHPLACE

Poplar Ida

OCCUPATION

House 2041

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *5:30* *A*. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

192(Signature) *[Signature]*

(Physician or midwife)

Address *Ida Falls*Filed *Oct 29**1927*

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 22 1927 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59208

Local Registrar's No. 1-1

County of Bonanza Registration District No. 73
City of Ida Falls Primary Registration District No. 21 N 70

(No. 1)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Bill Born

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
0 1927 9 20
If LESS than 1 day, ____ hrs. ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bill Born

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Ida Falls
(State or country)

10 NAME OF FATHER Edgar Nelson

11 BIRTHPLACE OF FATHER (city or town) Ida Falls
(State or country)

12 MAIDEN NAME OF MOTHER Hazel Ross

13 BIRTHPLACE OF MOTHER (city or town) Ida Falls
(State or country)

14 Informant Edgar Nelson
(Address) Ida Falls

15 Filed Sept 2, 1927 W. J. [Signature]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
9 20 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20 1927 to July 20 1927, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH was as follows:
Bill Born. Cause of
Lack of help - woman called him
after 13 days was born. Patient was unable to
Explain (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
(Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. J. [Signature] M. D.
9/20/27 19____ (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Ida Falls [Signature] Date of Burial Sept 21 1927

20. Undertaker [Signature] Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 3 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 155943**

County of Bonneville
City of Idaho Falls
No. 844-116-010-863 St.
L. D. S. Hospital
(If born in hospital or institution
give name.)

Registration District No. 23 State File No. _____

Prim. Registration District No. 2 Local Registrar's No. 422

FULL NAME OF CHILD Hudman, stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	<input checked="" type="checkbox"/> Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other?	and <input checked="" type="checkbox"/> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 16 1927</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn _____

FATHER
FULL NAME Hudman, Nathan
Residence (Usual place of abode) Idaho Falls, Ida
If nonresident, give place and State _____
Color or race white Age at last Birthday 33 (Years)
Birthplace Utah (City and State or Country)
Occupation Boatkeeper

MOTHER
FULL MAIDEN NAME Holley, Annie
Residence (Usual place of abode) Idaho Falls
If nonresident, give place and State _____
Color or race white Age at last Birthday 35 (Years)
Birthplace Utah (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:00 p. M.
on the date above stated.

(Signature) T. H. Hollister

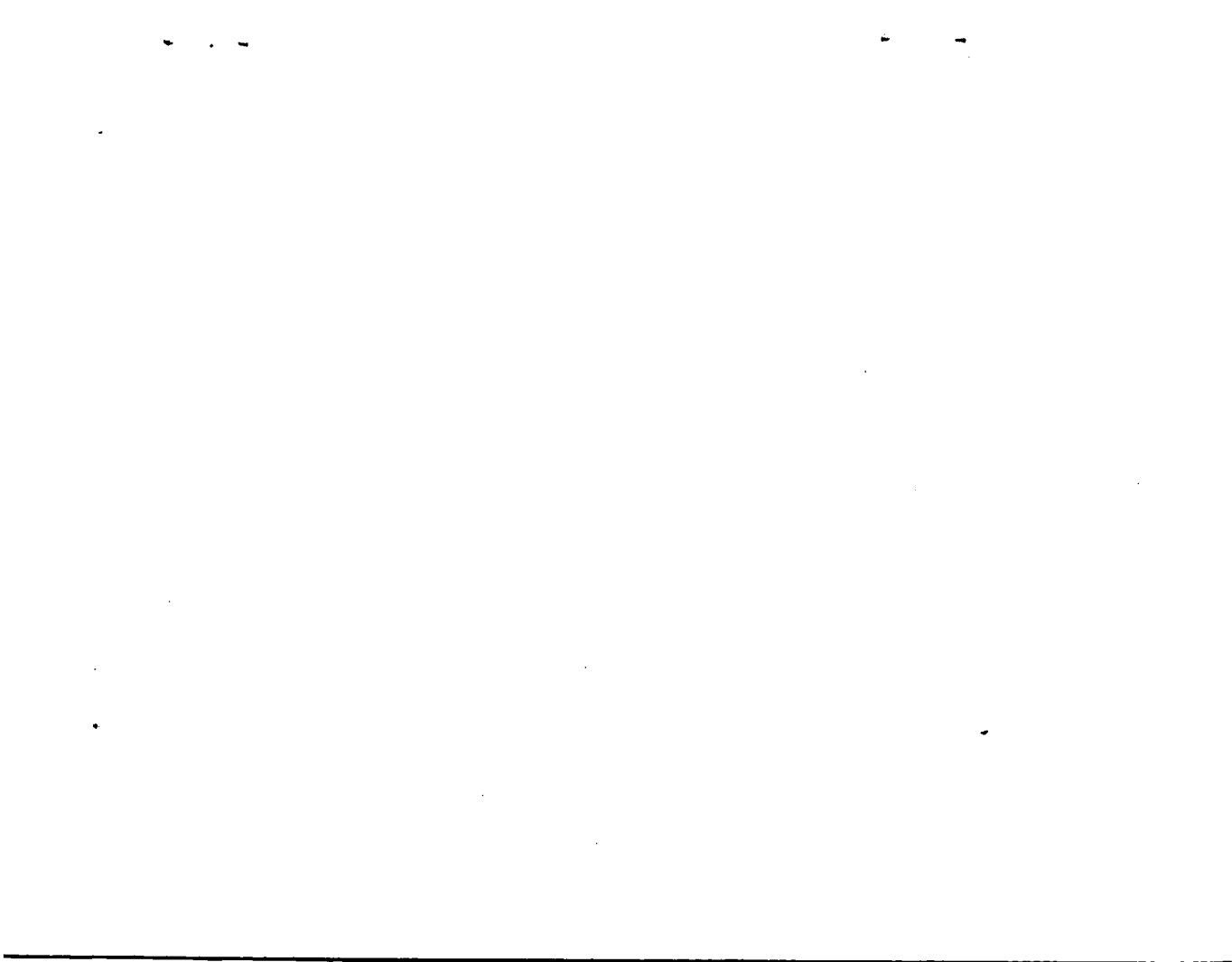
(Physician or midwife)

Address Idaho Falls, Ida.

Filed Oct 21 1927 W. H. H. H. H.

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



NOV 3 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **59189**

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21ND

(No. L.D.S. Hospital)

Local Registrar's No. 139

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Kenneth Hudman

(a) Residence. No. Idaho Falls R.F.D.#5 St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
-----------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 16, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>6</u>	<u>0</u>	<u>0</u>	

8. **OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. **BIRTHPLACE** (city or town) Idaho Falls, Idaho
(State or country)

10. **NAME OF FATHER** Arthur Hudman

11. **BIRTHPLACE OF FATHER** (city or town) Ogden, Utah
(State or Country)

12. **MAIDEN NAME OF MOTHER** Sarah Ann Holley

13. **BIRTHPLACE OF MOTHER** (city or town) Ogden, Utah
(State or Country)

14. Informant Arthur Hudman
(Address) Idaho Falls, Idaho

15. Filed Oct 17 19 27 Certified
Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

October 16 19 27
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? J.C. Hollister

(Signed) _____, M. D.

Oct. 17 1927 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal <u>Rose Hill, Idaho Falls</u>	Date of Burial <u>Oct. 17</u> 19 <u>27</u>
---	---

20. Undertaker <u>Jack A. Wood</u>	Address <u>Idaho Falls</u>
---------------------------------------	-------------------------------

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

H 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Idaho

City of Cottonwood

No. 654-215-025-254 St.

(If born in hospital or institution
give name.)

Registration District No. 105 State File No. 156126

Prim. Registration District No. 2183 Local Registrar's No. 73

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct. 15 1927</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Clara Stenholm</u>	MOTHER FULL MAIDEN NAME <u>Agnes Sembert</u>
---	---

Residence (Usual place of abode) Cottonwood

If nonresident, give place and State Humphrey, Neb.

Color or race W. Age at last Birthday 31 (Years)

Birthplace Humphrey, Neb. (City and State or Country)

Occupation Farming

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 1:45 A. M.
on the date above stated.

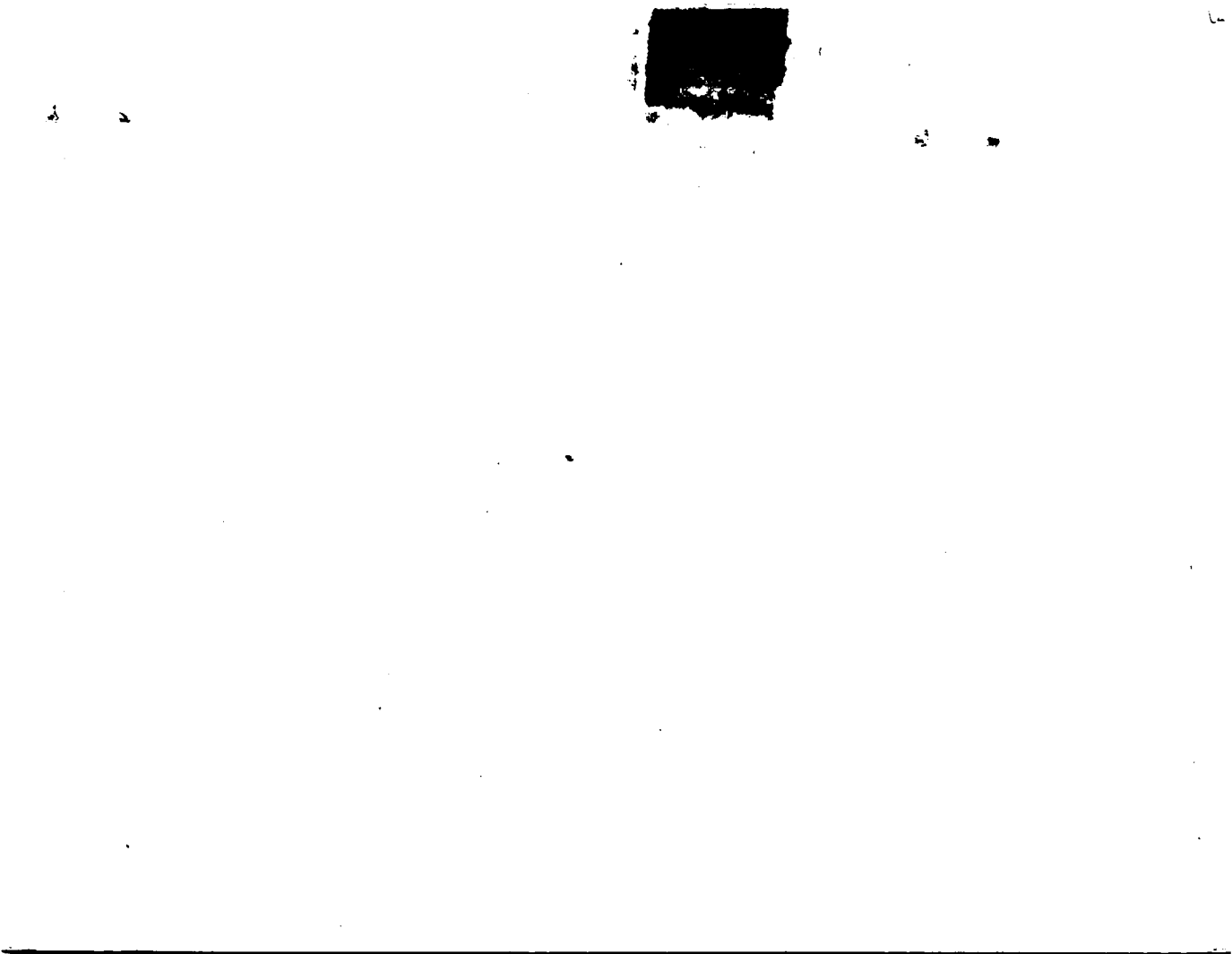
(Signature) Wesley F. Orr M.D.

(Physician or midwife)

Address Cottonwood, Ida

Filed Nov -1 1927 Wesley Orr
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. **RECEIVED** NOV 10 1927

CERTIFICATE OF DEATH.

59275

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of CottonwoodRegistration District No. 105
Primary Registration District No. 2183
(No. _____ St.)File No. 18
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Oct 15 1927
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Cottonwood
Idaho

10. NAME OF FATHER

Clem W. Emhoff

11. BIRTHPLACE OF FATHER

(State or Country)

Humphrey
Nebraska

12. MAIDEN NAME OF MOTHER

Agnes Benkert

13. BIRTHPLACE OF MOTHER

(State or Country)

Cottonwood
Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Aug. Haene
Cottonwood, Ida.

15.

Filed

Oct. 15 1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

194 ✓

16. DATE OF DEATH

Oct 15 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191_____ to _____ 191_____

that I last saw h_____ alive on _____ 191_____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pruritic, which due to
perforated appendix(Duration) _____ Yrs. _____ mos. 2 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wesley L. Orr M. D.10/15/27 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, Ida. Oct. 15 1927

20. UNDERTAKER

ADDRESS

W. Millibard Cottonwood, Ida.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

445 111-029-386

RECEIVED NOV 10 1927

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S 156176

County of Latah

City of Gardiner, W. R. D.

Registration District No. 61

File No. _____

No. _____ St. _____

Primary Registration District No. 2141 Registered No. 122

Hospital ✓

FULL NAME OF CHILD Not Named (Stillborn)

Sex of Child <u>Male</u>	<u>Twins</u> Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>10-11-1927</u> (Month) (Day) (Year)
--------------------------	--	-----	--------------------------	------------------------	---

FATHER
FULL NAME Pallard R. Munsey

RESIDENCE Gardiner, W. R. D.

COLOR White AGE AT LAST BIRTHDAY 35
(Years)

BIRTHPLACE Gardiner, W. R. D.

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Beneah Charles

RESIDENCE Gardiner, W. R. D.

COLOR White AGE AT LAST BIRTHDAY 26
(Years)

BIRTHPLACE Mo.

OCCUPATION House Wife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4⁴⁵ A. M.
on the date above stated. (Born alive or stillborn)

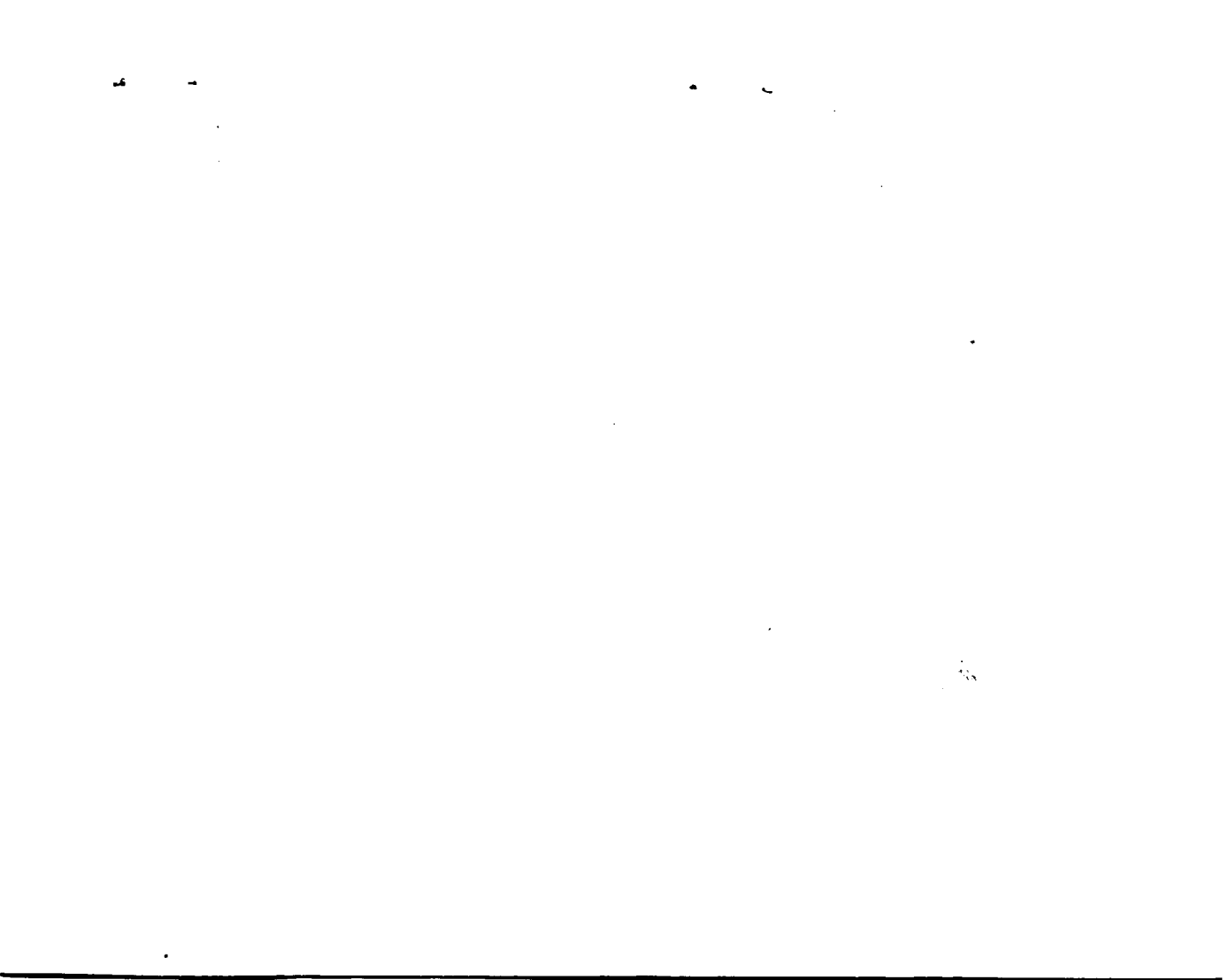
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. C. Brandon
Physician & Surgeon
(Physician or midwife)

Given names added from a supplemental report. _____
19. _____

Address Gardiner, W. R. D.
Filed 10-13-1927 W. H. Carithers
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S. F. No. 825—1921. Approved as to Form by Dept. of Efficiency. 2251.

59624

RECEIVED

County of LatahCity or Town of near Patach

Idaho Washington State Board of Health BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Record No. 65Registered No. 2145Registration Dist. No. No. 2. FULL NAME Baby Murrey(a) Residence No. St.;

(Usual place of abode)

(b) If non-resident, give city or town, and state Latah Co. Idaho

(c) How long in

Registration Dist. yrs. mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars

3. Sex Male 4. Color or Race white 5. Single, Married, Widowed or Divorced (Write the word) Single

5. (a) If married, widowed or divorced:

Husband of

or

Wife of 6. Date of birth October 11 1927

(Month)

(Day)

(Year)

7. Age Stillborn If less than one dayyrs. mos. ds. hrs. or min.

8. Occupation of deceased:

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)(c) Name of employer 9. Birthplace (City or town) Freeze(State or country) Idaho

PARENTS

10. Name of Father Pollard Murrey
11. Birthplace of Father (City or town) Washington
(State or Country)
12. Maiden name of Mother Charles
13. Birthplace of Mother (City or town) Missouri
(State or Country)14. Informant Pollard MurreyAddress Garfield, Wash.15. Filed Oct 16-1927 1927 Dr. J. H. Murrey Registrar.

Medical Certificate of Death

16. Date of death 10-11 1927

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Born Dead 1927, to 1927that I last saw him alive on Stillborn 1927and that death occurred on the date stated above, at m.
(State the disease causing death, or in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL).

The CAUSE OF DEATH was as follows:

(Primary) Stillborn(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary) (Duration) yrs. mos. ds.18. Where was disease contracted if not at the place of death? (a) Did an operation precede death? Date of (b) Was there an autopsy? (c) What test confirmed diagnosis? (Signed) W. C. Brumpton M. D.10-11 1927 Address Garfield, Wash.19. Place of Burial, Cremation or Removal Freeze Idaho 10-17 192720. Undertaker W. C. Brumpton Address Colfax, Wash.

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions.

(Insert numbers of unanswered questions)

(Signature of Undertaker)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED

NOV 14 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewish

City of Salmon

CERTIFICATE OF BIRTH

156188

No 652-21430-396 St. Registration District No. 41 State File No. 156188

Hospital _____ Primary Registration District No. 411 Local Registrar's No. ✓

FULL NAME OF CHILD

5 mo girls

(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? ye Date of birth Oct-14 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth ✓

Number of child of this mother now living, including present birth _____

FULL
NAME

FATHER

Geo. Fickels

FULL
MAIDEN
NAME

MOTHER

Eunice Goney

RESIDENCE

Salmon

RESIDENCE

Salmon

COLOR

wh

AGE AT LAST

BIRTHDAY

44

(Years)

COLOR

wh

AGE AT LAST

BIRTHDAY

41

(Years)

BIRTHPLACE

Hungary

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Hwb

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 4 a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. S. Wright

(Physician or midwife)

Address

Salmon

Filed Nov 10 1927

Chas. Bellamy

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of BohemiaCity of ReynoldsNo. 219-111.033.319 St.(If born in hospital or institution
give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 100 State File No. 156208Prim. Registration District No. 2178 Local Registrar's No. 240

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
ChildMaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birthOct. 11

(Month) (Day)

1927
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0Born alive but now dead 0 Stillborn 1FULL
NAMELester James Barrott

FATHER

Residence (Usual place of abode)

Reynolds

If nonresident, give place and State

Color or race

W

Age at last Birthday

21
(Years)

Birthplace

Reynolds, Idaho

(City and State or Country)

Occupation

FarmerFULL
MAIDEN
NAMEElla Grace Gazier

MOTHER

Residence (Usual place of abode)

Reynolds

If nonresident, give place and State

Color or race

W

Age at last Birthday

19
(Years)

Birthplace

Twin Grove, Id.

(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:40 A M.
on the date above stated.

(Signature)

H. B. Byrd M.D.

(Physician or midwife)

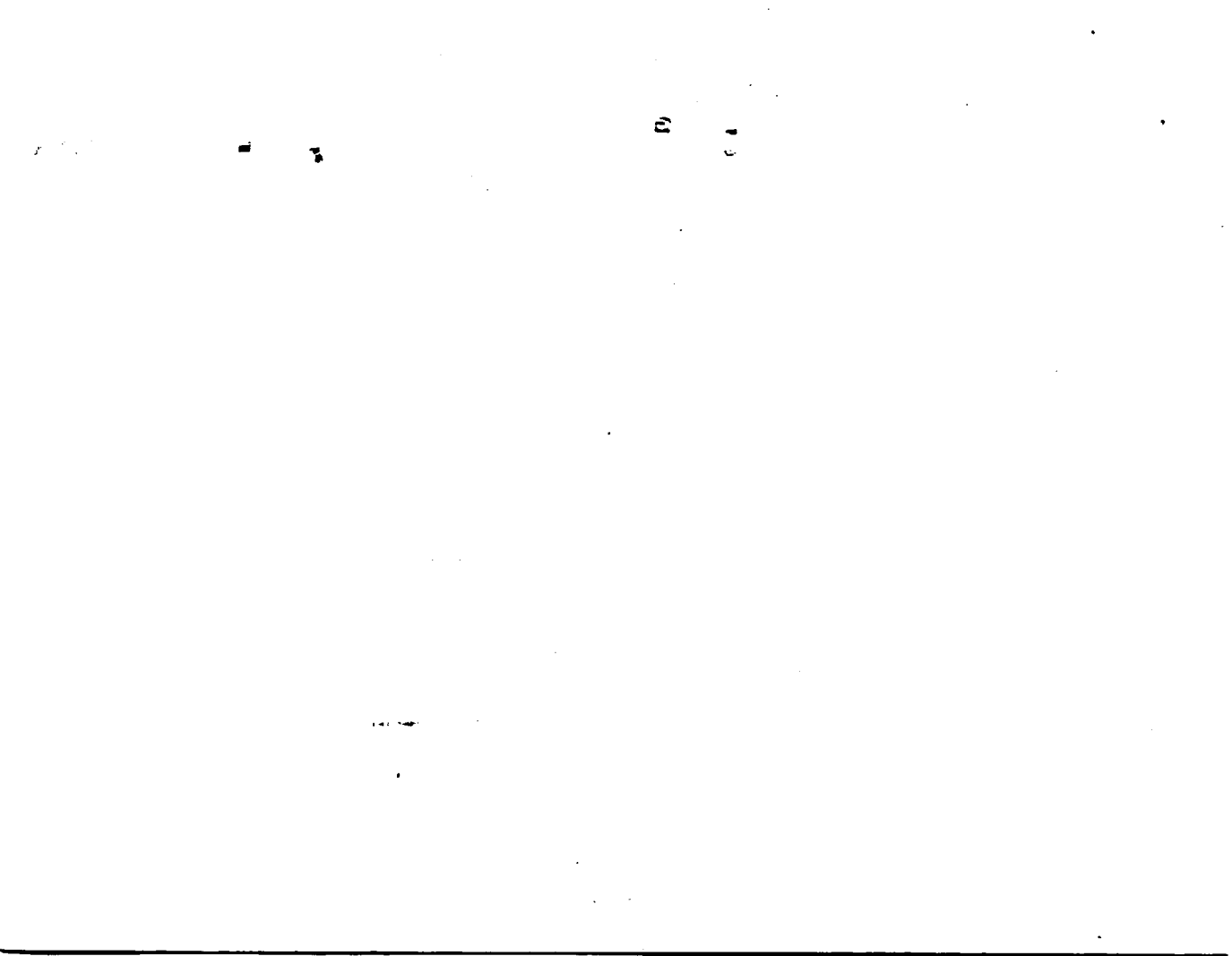
*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address

Filed

10/2919 27J. W. Young

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59326

County of Madison
City of Rephung

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 75

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby - Barnatt

(a) Residence. No. Rephung Idaho St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Still born child

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. min.
Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stillborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rephung Idaho
(State or country)

10. NAME OF FATHER Lester J. Barnatt

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MOTHER NAME OF MOTHER Ella Grace Garvin

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Lester J. Barnatt
(Address) Rephung Idaho

15. Filed 11-3 1927 W. H. Long Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 11 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY Stillborn, cad. w. my
(Secondary) w. ch.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) W. H. Long, M. D.
Oct. 12, 1927 (Address) Rephung

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rephung, Ida. Date of Burial Oct. 12 1927

20. Undertaker W. H. Long Address Rephung

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 9 1927

STATE OF IDAHO

County of Mundana

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

City of Rupert

CERTIFICATE OF BIRTH

No. 168-126-034-419 St.

Registration District No. 19 State File No. 156223

(If born in hospital or institution give name.)

Prim. Registration District No. 2013 Local Registrar's No. 179

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and {	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>10 26 1927</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? neo. Salvarsan 15.70

Number of child of this mother, including present birth 8 (a) Born alive and now living 7

Born alive but now dead 1 Stillborn

FATHER
FULL NAME Herman Albert Johnson

MOTHER
FULL MAIDEN NAME Mary M. Marlandale

Residence (Usual place of abode) Rupert

Residence (Usual place of abode) Rupert

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 50

Color or race White Age at last Birthday 40

Birthplace Utah (Years)

Birthplace Utah (Years)

(City and State or Country)

(City and State or Country)

Occupation upholsterer

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:30 A. M. on the date above stated.

(Signature) E. E. Moore

(Physician or midwife)

Address Rupert, Ida.

Filed Nov 7 1927 E. E. Moore

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NR

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

993-228 035 7455
PLACE OF BIRTH

RECEIVED NOV 10 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Nez Perce
CITY OF Leviestown
No. _____ St. _____ Registration District No. 96 State File No. 156244
Hospital St. Joseph Primary Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Girl Twin Triplet or other? _____ and { Number in order of birth 2nd } Legitimate? yes Date of birth Sept. 28 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2
FATHER FULL NAME Bert Richardson MOTHER FULL MAIDEN NAME Orpha Dennis
RESIDENCE Clarkston Wn. RESIDENCE Clarkston Wn.
COLOR White AGE AT LAST BIRTHDAY 30 COLOR White AGE AT LAST BIRTHDAY 22
(Years) (Years)
BIRTHPLACE Ark. BIRTHPLACE Idaho
OCCUPATION Warehouseman OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive { born alive } at 8:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1927

(Signature) B. Stuchley

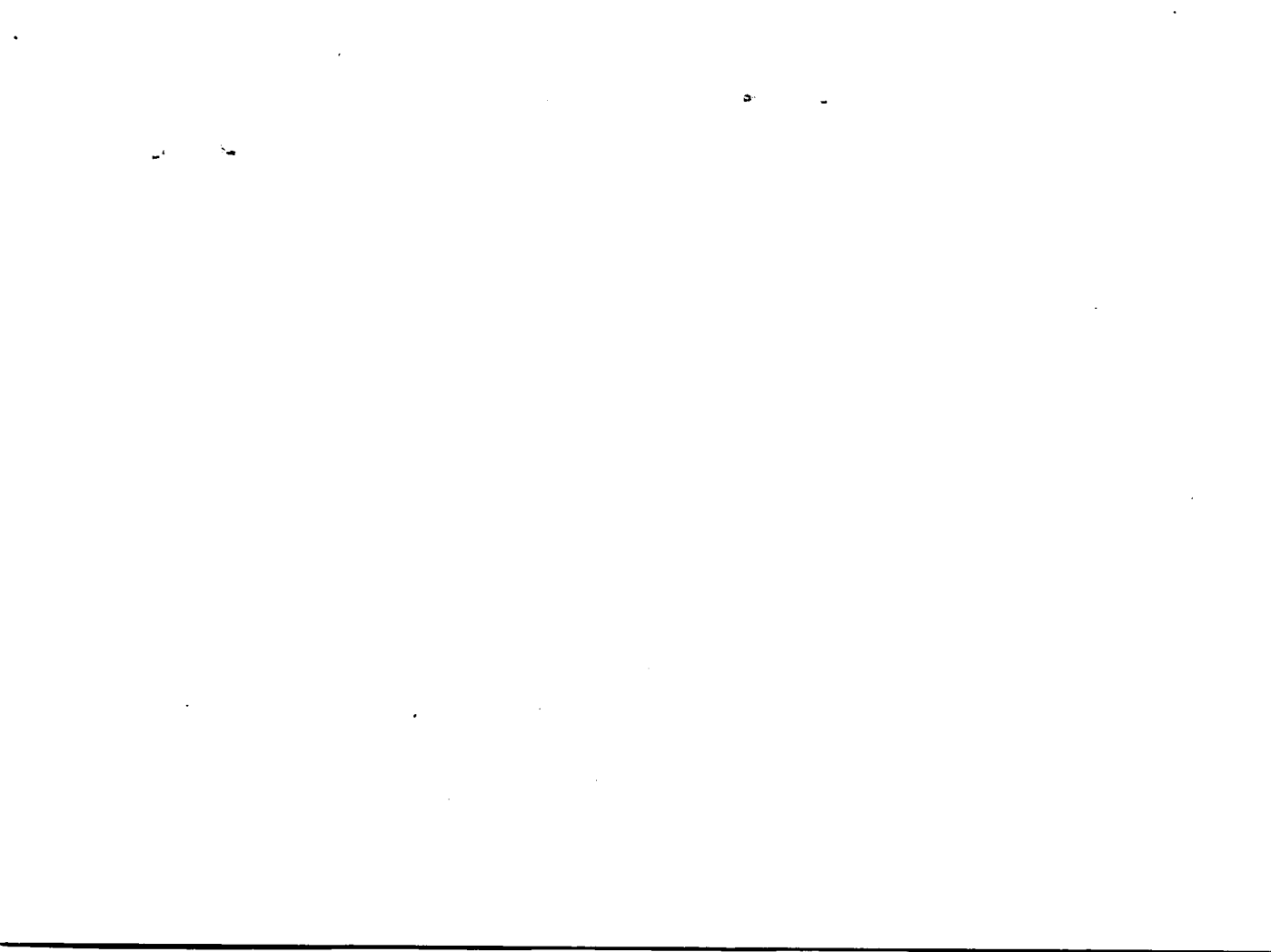
(Physician or midwife)

Address Leviestown Ida

Filed Nov 6 1927 Susan E Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59043

RECEIVED OCT 8 - 1927
PLACE OF DEATH

County of Payette
City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Baby Richardson

(a) Residence. No. 3rd St Clarkston Wash. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Still Born

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Still Born

6 DATE OF BIRTH (month, day and year) Sept 29 - 1927

7 AGE Still Born Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED Still Born

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

10 NAME OF FATHER Bert Richardson

11 BIRTHPLACE OF FATHER (city or town) Powell Ark.
(State or country)

12 MAIDEN NAME OF MOTHER Opheie Higgins

13 BIRTHPLACE OF MOTHER (city or town) Proctor Idaho
(State or country)

14 Informant Bert Richardson

(Address) Clarkston Wash.

15 Filed Oct 4, 1927 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 29 19 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 29, 1927 to Sept 29, 1927.
that I last saw him alive on Sept 29, 1927
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Respiratory Depression
placental

CONTRIBUTORY (Secondary) Long history
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) L. B. Hockaday M. D.

, 10/1, 1927 (Address) Clarkston Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial Sept 29 1927

20. Undertaker Wasson Undertaking Co Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

849 109 035 763
PLACE OF BIRTH

RECEIVED NOV 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

156252

County of Nezperce
City of Clarkston
No. 1 St. Registration District No. 96 File No. 156252
Hospital St. Joseph Primary Registration District No. 1009 Registered No. _____
FULL NAME OF CHILD Richard Miles Grigley
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u> and <u>Number in order of birth</u> <u>-</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 9</u> <u>1927</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bactericidal solution was used in eyes? Yes

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Robt. M. Grigley</u>	FULL MAIDEN NAME	<u>Eveline Watt</u>
RESIDENCE	<u>Clarkston, Washington</u>	RESIDENCE	<u>Clarkston, Washington</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>25</u> (Years)	AGE AT LAST BIRTHDAY	<u>18</u> (Years)
BIRTHPLACE	<u>Nebraska</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Officer at Mill</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was at M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

John A. Alley
Leviston
(Physician or midwife)

Give names added from a supplemental report.

Address

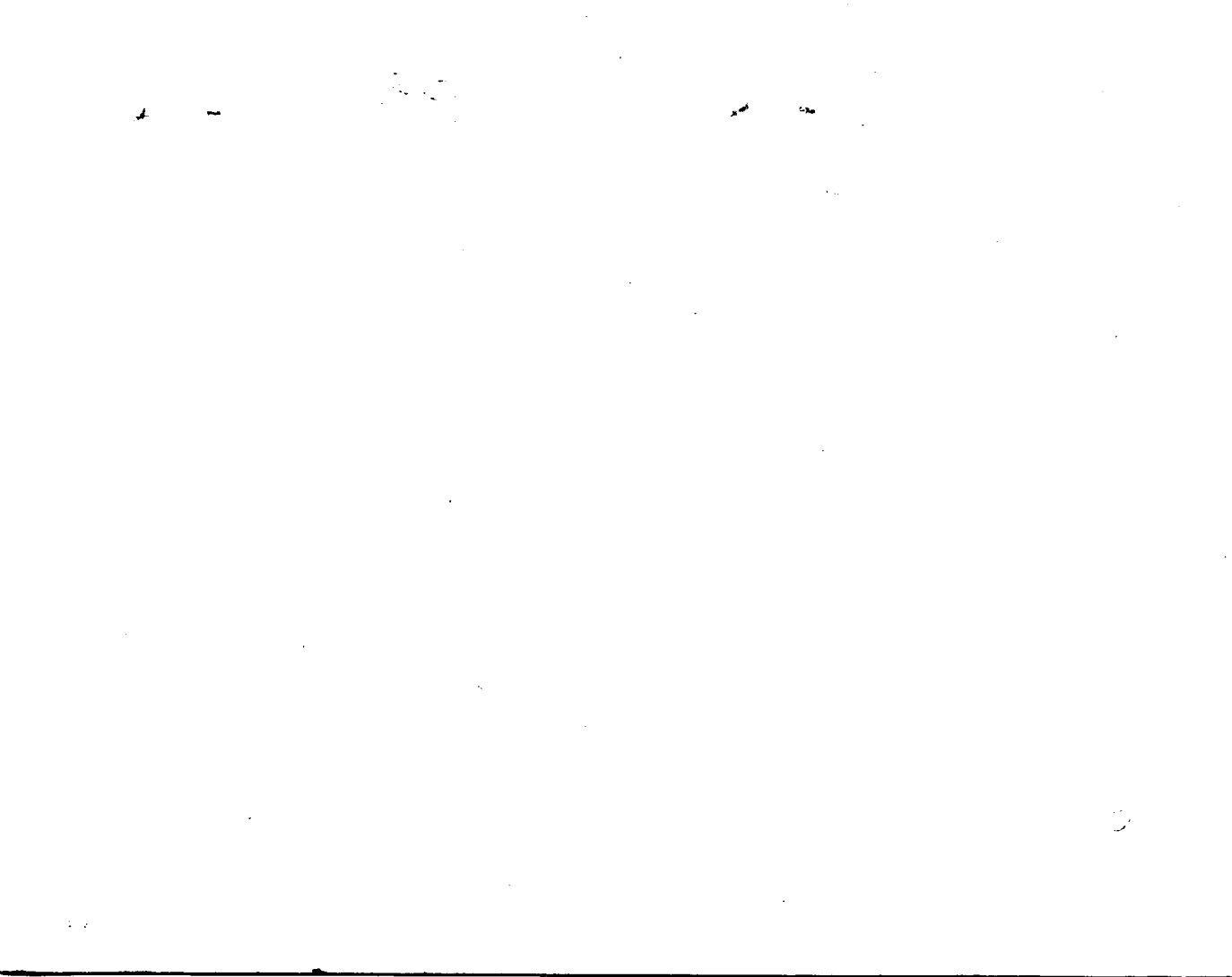
Filed

Nov 6 1927

Susan E Bruce

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59340

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Naz. perca.

Registration District No.

Local Registrar's No.

City of Lewiston.

Primary Registration District No.

(No. St. Joseph hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Miles Quigly

(a) Residence. No. St. Clarkston, Washington.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 10/7/27.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

10 NAME OF FATHER Robert Quigley.

11 BIRTHPLACE OF FATHER (city or town) Nebraska.
(State or country)

12 MAIDEN NAME OF MOTHER Eva Watt,

13 BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or country)

14 Informant L. B. Wann
(Address) Lewiston, Idaho.

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 7th, 1927.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Stillborn
Placental Prevalence
Shoulder Presentation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) John H. Kelly, M. D.
_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 10/8/27. 19

20. Undertaker Brower-Wann Company Address Lewiston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 14 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Mace Ida.

No. 667-203-040 265

Registration District No. 70 State File No. 156340

Hospital _____ Primary Registration District No. 1011 Local Registrar's No. 136

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u> }</u> and { Number in order of birth <u> }</u>	Legitimate? <u>Yes</u>	Date of birth <u>10-3-1927</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Elmer M. Fogelson
RESIDENCE Mace Ida.
COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Minnesota
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Lydia Buckel
RESIDENCE Mace Ida.
COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Nebraska
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

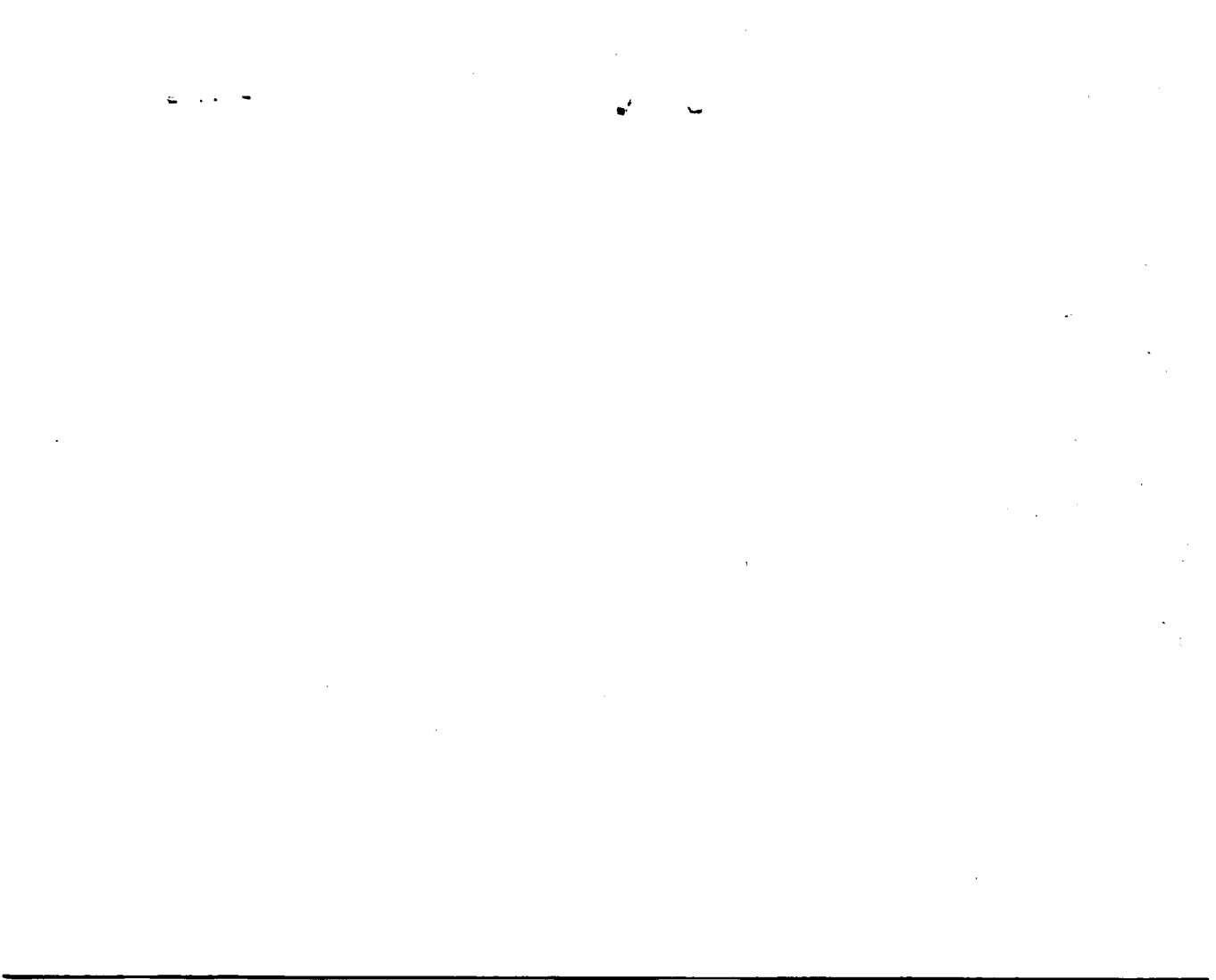
(Signature) Dr. MOWERY
Physician
(Physician or midwife)

Address Wallace, Ida.

Filed Nov 4 1927 F. L. Linsley

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED NOV 14 1927
PLACE OF DEATH
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59369

County of Boise Registration District No. 72
City of Boise Primary Registration District No. 1011
(No. Boise, Idaho)
If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Infant of Mr & Mrs. E. M. Fogelson
(a) Residence. No. Burke Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)
6a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____
6 DATE OF BIRTH (month, day and year) Oct 3 1927
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

16 DATE OF DEATH Oct 3 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw her alive on _____ 19____, and that death occurred, on the date stated above, at 11 a m. The CAUSE OF DEATH* was as follows
Still born

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis? _____ (Signed) Dr. M. W. Egert M. D.
1927 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Remains Wallace Date of Burial 10/4 1927

20 Undertaker Brueck Mortuary Address Wallace

9 BIRTHPLACE (city or town) Burke Idaho (State or country)
10 NAME OF FATHER E. M. Fogelson
11 BIRTHPLACE OF FATHER (city or town) Minnesota (State or country)
12 MAIDEN NAME OF MOTHER Lydora Beckel
13 BIRTHPLACE OF MOTHER (city or town) Nebraska (State or country)
14 Informant E. M. Fogelson (Address) Burke Ida
15 Filed Cent, 1927 Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

619-112044-362
PLACE OF BIRTH

RECEIVED OCT 21 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Washington
City of Weiser

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 86 File No. 156459
Hospital _____ Primary Registration District No. 212 Registered No. 27

FULL NAME OF CHILD Still born.

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept-12</u> 192 <u>7</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 2

FULL NAME FATHER
John Warrick
RESIDENCE Weiser
COLOR white AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Penn
OCCUPATION Farmer

FULL MAIDEN NAME MOTHER
Gladys Colvig
RESIDENCE Weiser
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Oreg
OCCUPATION house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated. (Born stillborn) 12 a M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F A Schmitt

(Physician or midwife)

Give names added from a supplemental report.

Address Weiser Idaho

Filed Oct-10 1927 W R. Haun Registrar.

Registrar.

ND

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED DEC 2 1927 STATE OF IDAHO
County of Blaine DEPARTMENT OF PUBLIC WELFARE
City of Carey BUREAU OF VITAL STATISTICS
No. St.
231005 007361 Registration District No. 57 State File No. 156661
(If born in hospital or institution give name.) Prim. Registration District No. 2.25 Local Registrar's No. 49

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child ☒ Male ☐ Female
Twin ☐ Triplet ☐ or other? ☐ and { Number in order of birth }
Legitimate? yes Date of birth Oct 5 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead Stillborn 1

FATHER	MOTHER
FULL NAME <u>John D. Blacknell</u>	FULL MAIDEN NAME <u>Grace Ellen Coates</u>
Residence (Usual place of abode) <u>Carey, Ida</u>	Residence (Usual place of abode) <u>Carey, Ida</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>white</u> Age at last Birthday <u>30</u>	Color or race <u>white</u> Age at last Birthday <u>33</u>
Birthplace <u>Missouri</u> (City and State or Country)	Birthplace <u>Utah</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 6:30 A M.
on the date above stated. { Stillborn }

(Signature) Robert H. Wright-M.D.

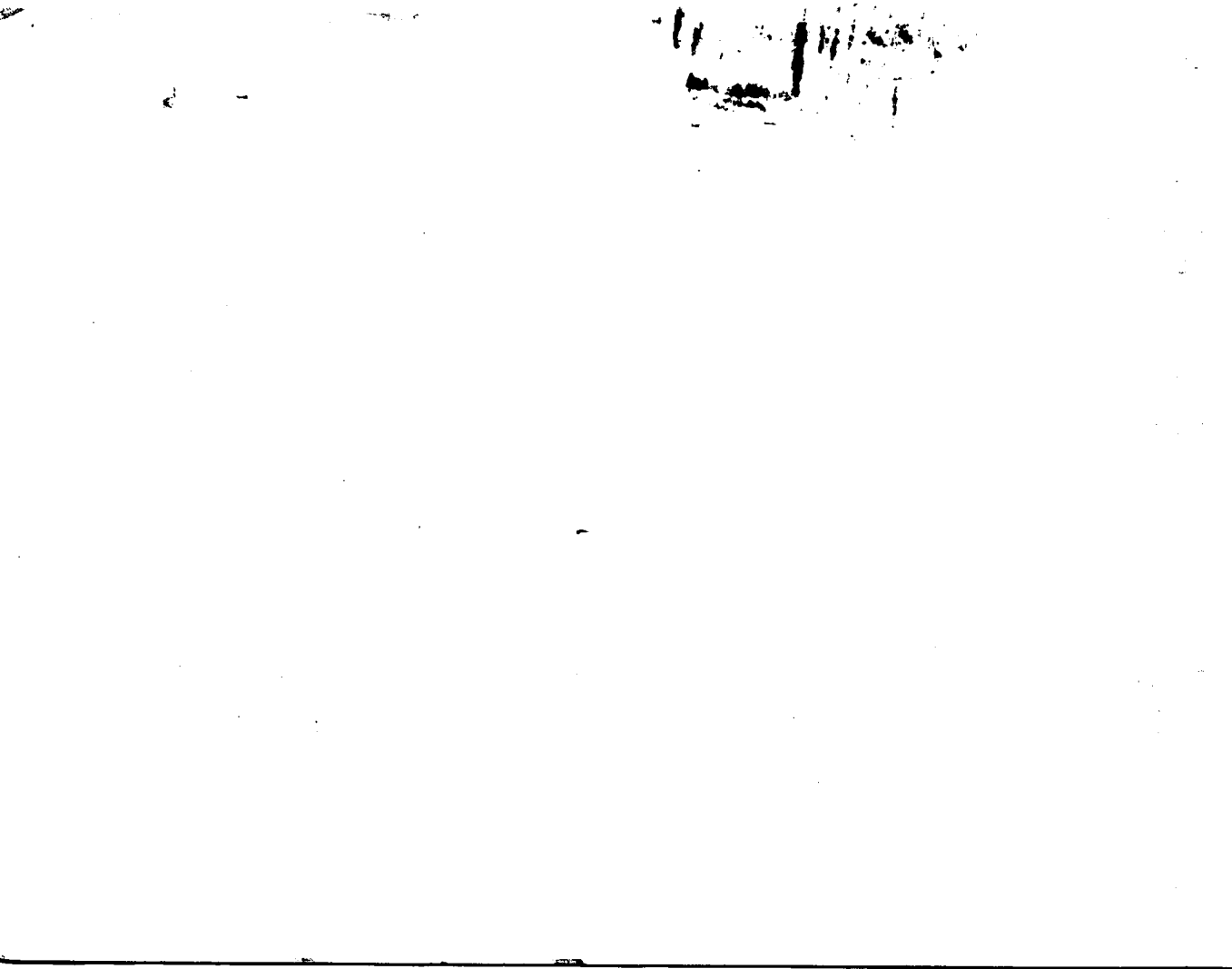
(Physician or midwife)

Address Hailey, Ida

Filed 10-6 1927

Robert H. Wright
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 59506

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2025

Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Blacknell (Stillborn)

(a) Residence No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-5-1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Carey, Idaho
(State or country)

10. NAME OF FATHER John D. Blacknell

11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Grace Ellen Coates

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Robert H. Wright-M.D.
(Address) Hailey, Ida.

15. Filed 10-6-1927 Robert H. Wright-Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw him alive on 6-30-1927
and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert H. Wright M.D.
10/6 1927 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Carey, Ida Date of Burial 10-6-1927

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

431703 040-257
PLACE OF BIRTH

RECEIVED NOV 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS-

S

County of Shoshone
City of Kellogg
No. W. Minnich St. Registration District No. 123 State File No. 156355
Hospital _____ Primary Registration District No. 2201 Local Registrar's No. 106
FULL NAME OF CHILD McAnney

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legiti- mate? yes Date of birth 7/3/1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Cargol 5%

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Amrose Eugene McAnney
RESIDENCE Kellogg, Idaho.
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Winn.
OCCUPATION School-teacher

MOTHER
FULL MAIDEN NAME Katherine Sexton
RESIDENCE Kellogg, Idaho.
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Winn.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at 29 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

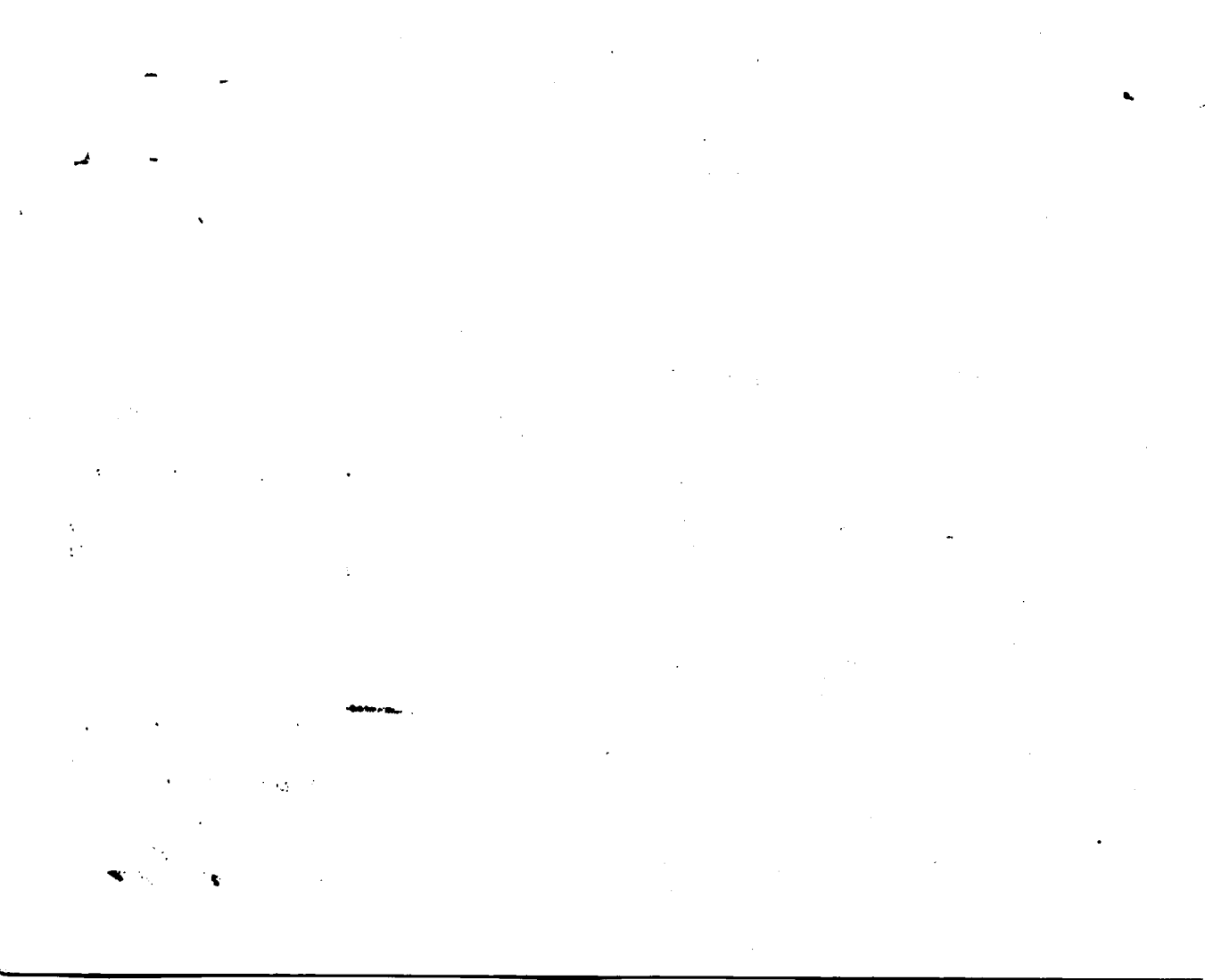
(Signature) A. S. Woodruff
Physician
(Physician or midwife)

Address Kellogg, Idaho.

Filed Oct. 30 1927 Mrs. Helen M. Bide

Registrar.

Registrar.



FORM V. S. No. 5-25 M. A. 19.

1. PLACE OF DEATH

County of ShoshoneCity of Kellogg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District

Primary Registration District No. 2201

(No. _____ St.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICSState File No. 58101

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmale White

(Write the word)

6. DATE OF BIRTH

July 3 1927
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of workBaby(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg, Idaho10. NAME OF
FatherA. E. McAdams11. BIRTHPLACE
OF FATHER

(State or Country)

Waseca, Minn.12. MAIDEN NAME
OF MOTHERKatherine Sexton13. BIRTHPLACE
OF MOTHER

(State or Country)

Rogers, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. E. McAdams
415 W. Mississippi Ave.

15.

Filed

July 31927Dr. H. M. B. B. B.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July - 3 - 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillbirth 1927that I last saw h. alive on 1927

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Extrauterine pressureStillborn(Duration) _____ yrs. _____ mos. 5 hrs.

Contributory-

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. E. McAdams M. D.

7/3/1927

(Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Idaho July 4 1927

20. UNDERTAKER

ADDRESS

P. F. Thornhill Kellogg, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bonner
City of Sandpoint

DEC 3 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

156673

No. St.

593224 009 396

(If born in hospital or institution
give name.)

Registration District No. 76 State File No.

Prim. Registration District No. 9155 Local Registrar's No.

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child Female

Twin
Triplet
or other?

} and {

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth

November 24th 27
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0st (a) Born alive and now living None

Born alive but now dead None Stillborn One

FATHER

FULL
NAME Herman Nillson

Residence (Usual place of abode) Sandpoint, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 45
(Years)

Birthplace Germany

(City and State or Country)

Occupation

Cook

MOTHER

FULL
MAIDEN
NAME Martha Trost

Residence (Usual place of abode) Sandpoint, Idaho.

If nonresident, give place and State

Color or race White Age at last Birthday 39
(Years)

Birthplace Germany

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Sandpoint on the date above stated. 8.30 AM.

(Signature) D. B. Evans

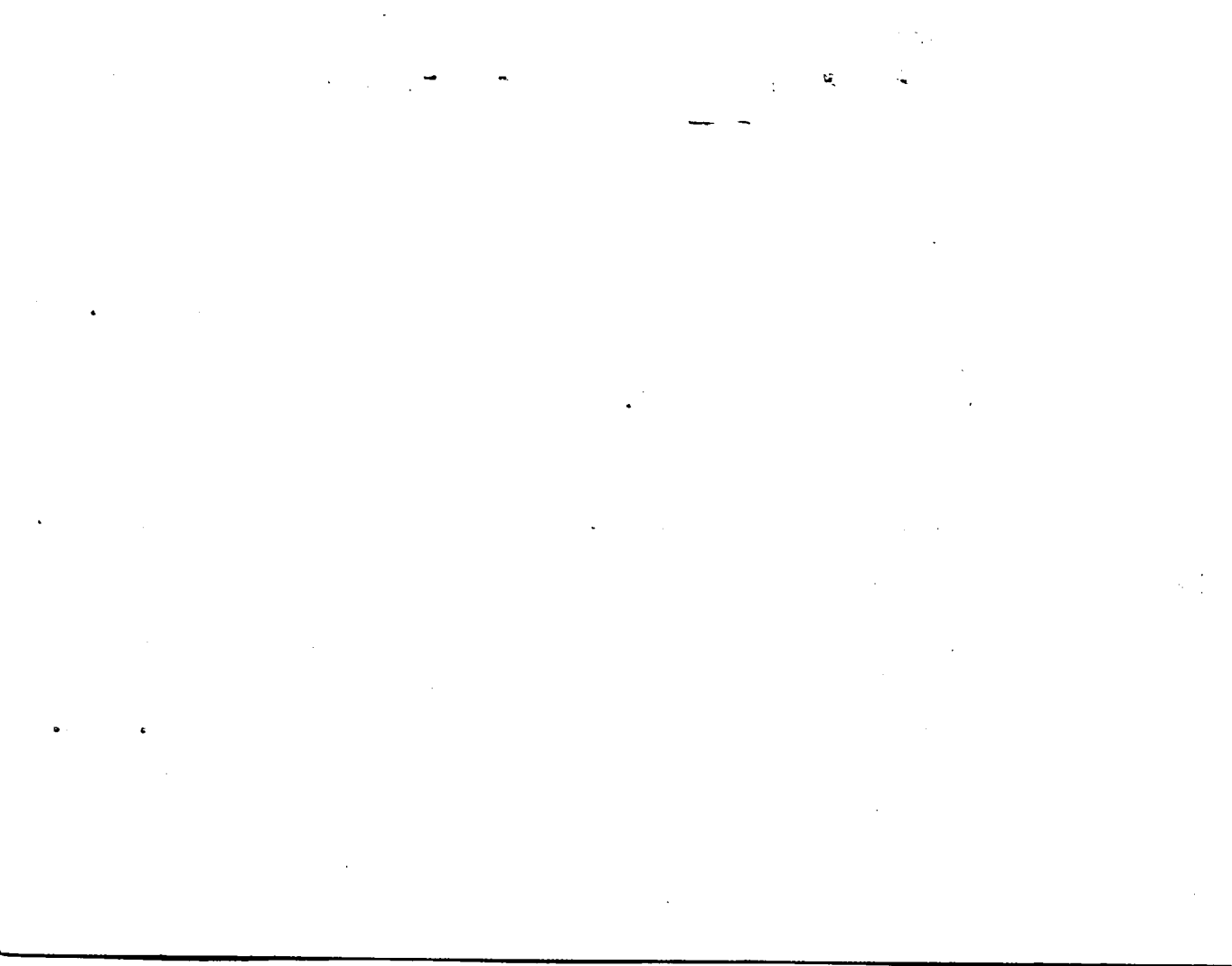
Physician

(Physician or midwife)

Address Sandpoint, Idaho.

Filed Dec 3 1927 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 3 1927

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59518

County of BonnerRegistration District No. 78City of SandpointPrimary Registration District No. 2153-

Local Registrar's No. _____

(No. 331 S Florence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Nilsson

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Still born Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Sandpoint Idaho (State or country)10. NAME OF FATHER Herman Nilsson11. BIRTHPLACE OF FATHER (city or town) Germany (State or Country)12. MAIDEN NAME OF MOTHER Martha Trost13. BIRTHPLACE OF MOTHER (city or town) Germany (State or Country)14. Informant Herman Nilsson (Address) 331 S Florence15. Filed 11/25, 1927 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 8:30 A.M.The CAUSE OF DEATH* was as follows: Stillborn due to prolonged labor in old primipara

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. B. Gray M. D.Nov 25, 1927 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery Date of Burial 11/26 192720. Undertaker Turnbull Co Address Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED DEC 8 1927

STATE OF IDAHO

County of Minidoka

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

City of Reupert

CERTIFICATE OF BIRTH

No. 363-230034867 St.

Registration District No. 19 State File No. 156778

(If born in hospital or institution give name.)

Prim. Registration District No. 2015 Local Registrar's No. 205

FULL NAME OF CHILD Stillborn Cole

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>He</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov. 30</u> 19 <u>27</u> (Month) (Day) (Year)
------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Edgar M. Cole

MOTHER
FULL MAIDEN NAME Nana Hogan

Residence (Usual place of abode) Reupert

Residence (Usual place of abode) Reupert

If nonresident, give place and State

If nonresident, give place and State

Color or race white Age at last Birthday 32
(Years)

Color or race white Age at last Birthday 34
(Years)

Birthplace Utah
(City and State or Country)

Birthplace Utah
(City and State or Country)

Occupation Master mechanic analg.

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 11 48 A. M. on the date above stated.

(Signature) E. E. Elmore

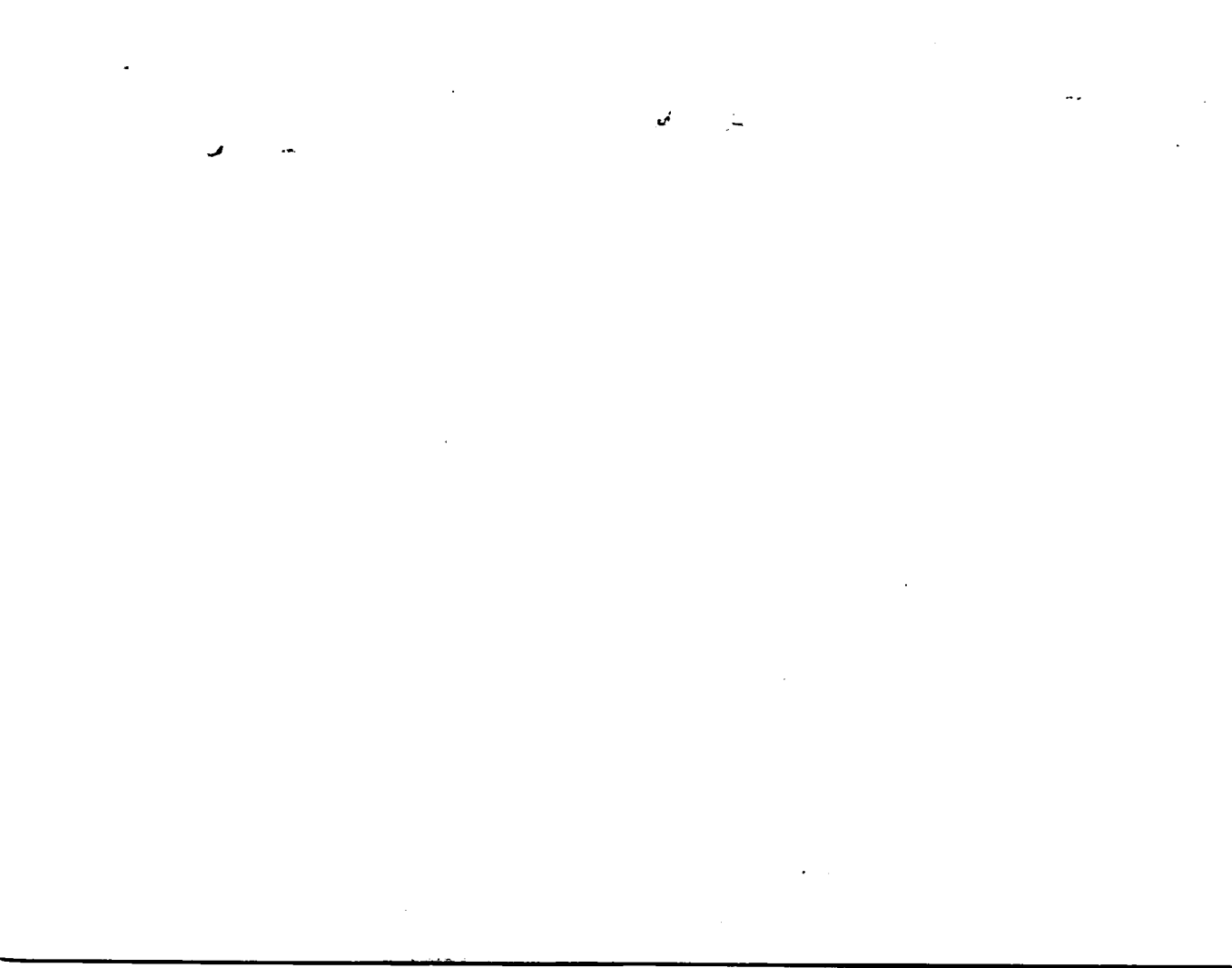
(Physician or midwife)

Address Reupert, Ida

Filed Dec 7 1927 E. E. Elmore

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **59652**

RECEIVED DEC 8 1927

PLACE OF DEATH

County of MuskegonCity of RupertRegistration District No. 19Primary Registration District No. 2016Local Registrar's No. 54(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Cole Stillborn

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. Single, Married, Widowed or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Nov 30 19277. AGE Years Months Days Stillborn Is LESS than 1 day, hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rupert Ida
(State or country)10. NAME OF FATHER Edggs M Cole11. BIRTHPLACE OF FATHER (city or town) Logan Utah
(State or Country)12. MAIDEN NAME OF MOTHER Nana Hogan13. BIRTHPLACE OF MOTHER (city or town) Newston Wt
(State or Country)14. Informant Edgar M Cole
(Address) 413 7th Rupert Idaho15. Filed Dec 1 1927 EDHE Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
Cause not known
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) EDHE M. D.
Dec 1 1927 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Logan Utah Date of Burial Dec 2 192720. Undertaker D.E. Johnson Address Bunley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

463-105016-38
PLACE OF BIRTH

County of Cassia
City of Regan

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 119 State File No. 156817
Hospital At home Primary Registration District No. 295 Local Registrar's No. _____
FULL NAME OF CHILD Raymond William Dolph
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? - and { Number in order of birth _____ } Legitimate? yes Date of birth Sept 5 - 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Boric acid

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Jesse Wm. Dolph
RESIDENCE Regan Idaho
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Calhoun Co. Iowa
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Nancy Irene Cahoon
RESIDENCE Regan Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Almo Idaho
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 10 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) W. L. Dolph M.D.

(Physician or midwife)

Address Malta Idaho

Filed Dec 10 1927 W. L. Dolph

Registrar.

Registrar.

RECEIVED
COUNTY OF
CLYDE

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 13 1927

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Cassia
City of Hager

Registration District No. 119Primary Registration District No. 2198

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 59560

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Sept 5 1927
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2]

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Hager Idaho

10. NAME OF FATHER

Jesse Wm. Daugh

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Raney Irene Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse W. Daugh(Address) Hager Idaho

15.

Filed Dec 19 1927 C. Foster

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 5 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

no 191... to no 191...

that I last saw him alive on no 191...

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born properly suppressed Cord.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. Foster M. D.19. (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HagerSept 6 1927

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

336-109 016-719
PLACE OF BIRTH

RECEIVED DEC 13 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Elba

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 119 State File No. 156818

Hospital at home Primary Registration District No. 2195 Local Registrar's No. _____

FULL NAME OF CHILD Veron Lloyd

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 9</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>Fred T Lloyd</u>	FATHER
RESIDENCE <u>Elba Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Elba Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Florence Ethel Parish</u>	MOTHER
RESIDENCE <u>Elba Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Elba Idaho</u>	
OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. Sater M.D.

(Physician or midwife)

Address Maeta Idaho

Filed Dec 10 1927

Registrar.

Registrar.

RECEIVED
JAN 10 1964
FBI - NEW YORK

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 59559

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

 1. PLACE OF DEATH **RECEIVED DEC 13 1927**
 County of Cassia Registration District No. 119
 City of Elba Primary Registration District No. 2198
 (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Lloyd

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH.

Sept 9 1927
 (Month) (Day) (Year)

7. AGE

21 yrs.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer).
None

9. BIRTHPLACE

(State or Country)

Elba, Idaho

10. NAME OF FATHER

Fred T. Lloyd

11. BIRTHPLACE OF FATHER

(State or Country)

Elba, Idaho

12. MAIDEN NAME OF MOTHER

Mossie E. The Parish

13. BIRTHPLACE OF MOTHER

(State or Country)

Elba, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Fred T. Lloyd

(Address)

Elba, Idaho

15.

Filed

Dec 10 1927
C. J. Sater
 Local Registrar

16. DATE OF DEATH

Sept 9 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____ to 191____

that I last saw him alive on 191____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Still born, due to an injury from a fall, one week before

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

C. J. Sater
 M. D.
 19____ (Address) Elba, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elba CemeterySept 16 1927

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

239-121018-281
PLACE OF BIRTH

RECEIVED DEC 3 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Clearwater

City of Elk River

CERTIFICATE OF BIRTH **156824**

No. St. Registration District No. 91 State File No.

Hospital Elk River Primary Registration District No. 2168 Local Registrar's No. 158

FULL NAME OF CHILD Baby Stillman

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>November 21 1927</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>David Benjamin Stillman</u>	FULL MAIDEN NAME <u>Emma Sharra</u>
RESIDENCE <u>Elk River, Id.</u>	RESIDENCE <u>Elk River, Id.</u>
COLOR <u>Wh.</u>	COLOR <u>Wh.</u>
AGE AT LAST BIRTHDAY <u>41</u> (Years)	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Wisconsin</u>	BIRTHPLACE <u>Iowa</u>
OCCUPATION <u>Planing Mill Man</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:45 P.M. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Chas. H. M.D.

(Physician or midwife)

Address Elk River Idaho

Filed Nov. 30 1927 Mildred Hambley

Registrar.

Registrar.



State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **59600**
 Registered No. **36**

1. **PLACE OF DEATH.** Registration District No. **-91-**
 County of **Clearwater** Primary Registration District No. **2168**
 City of **Elk River** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** **Daby Stillman**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. **SEX** **Male** 4. **COLOR OR RACE** **White** 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.**
 (Write the word.)

6. **DATE OF BIRTH**
 _____ 11 _____ 21 _____ 1927
 (Month) (Day) (Year)

7. **AGE** _____ yrs. _____ mos. _____ ds. IF LESS than 1 day
 how many **NO.** e. hrs. or
 _____ min?

8. **OCCUPATION**
 (a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE**
 (State or Country) **Elk River Idaho.**

10. **NAME OF FATHER** **David Stillman**

11. **BIRTHPLACE OF FATHER**
 (State or Country) **Wisconsin**

12. **MAIDEN NAME OF MOTHER** **Emma Sharra**

13. **BIRTHPLACE OF MOTHER**
 (State or Country) **Iowa**

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) **D.B. Stillman**
 (Address) **Elk River Idaho.**

15. **Local Registrar**
Mildred Hambley
Nov. 30 1927

16. **DATE OF DEATH**
 _____ 11 _____ 21 _____ 1927
 (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from
 _____ 11/21 _____ 1927, to _____ 191
 that I ~~last~~ **never** saw him alive on _____ 191
 and that death occurred on the date stated above, at _____ M.

The **CAUSE OF DEATH*** was as follows:
Low implantation of placenta, complicated by abruptio. Period of gestation estimated at eight months.

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (Secondary)

(Signed) **W. M. Kusted** M. D.
12/1 1927 (Address) **Elk River, Id.**

*State the **DISEASE CAUSING DEATH**; or in deaths from **VIOLENT CAUSES**, state (1) **MEANS OF INJURY**; (2) whether **ACCIDENTAL, SUICIDAL or HOMICIDAL**.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.

19. **PLACE OF BURIAL OR REMOVAL** **DATE OF BURIAL**
 _____ **11/22/1927**

20. **UNDERTAKER** **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Franklin
City of Mink Creek, Ida

No. 815-113-021-389 St. Registration District No. 27 State File No. 156847

Hospital _____ Primary Registration District No. 2114 Local Registrar's No. 237

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>YES</u>	Date of birth. <u>NOV 13</u> 192 <u>7</u> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	--------------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8

Number of child of this mother now living, including present birth 7

FULL
NAME

FATHER

John M. Hansen
RESIDENCE Mink Creek, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

51

(Years)

BIRTHPLACE

Denmark

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Hannah Christensen
RESIDENCE Mink Creek, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

40

(Years)

BIRTHPLACE

Mink Creek, Ida

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11-20 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. W. Stiles

M. D.

(Physician or midwife)

Address

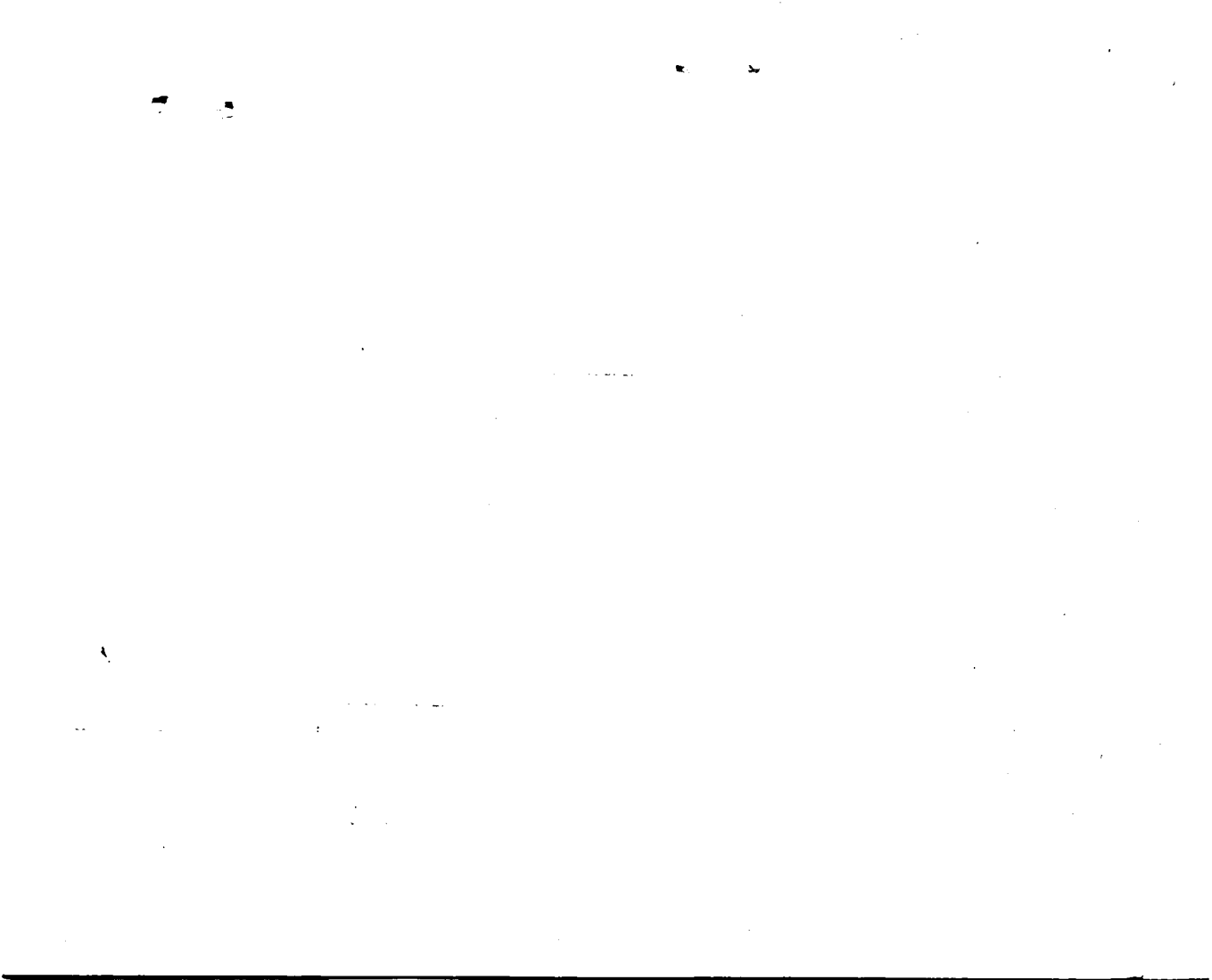
Preston, Ida

Filed

Dec. 3 192 7

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-18

RECEIVED DEC 3 1927

1. PLACE OF DEATH

County of Franklin

City of Mink Creek, Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 27

Primary Registration District No. 2119

(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 59606

Local Registrar's No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

Nov 13 1927
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mink Creek, Ida

10. NAME OF

Father John M. Hansen

11. BIRTHPLACE

OF FATHER Denmark
(State or Country)

12. MAIDEN NAME

OF MOTHER Hannah Christensen

13. BIRTHPLACE

OF MOTHER Mink Creek, Ida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Hansen
(Address) Mink Creek, Ida

15.

Filed Dec. 3 1927 J. R. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 13 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1927 to Nov 13 1927, that I last saw h. alive on 1927, and that death occurred on the date stated above at M.

The CAUSE OF DEATH* was as follows: Child still born - Been dead several days before birth

(Duration) yrs. mos. ds.
Contributory Premature detachment of placenta
(Secondary)
(Signed) G. W. States M. D.
19 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mink Creek, Ida

DATE OF BURIAL

11/13 1927

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Idaho DEC 3 1927 STATE OF IDAHO

County of Teton DEPARTMENT OF PUBLIC WELFARE
City of Teton, Idaho BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 693-118022-266 St.

Registration District No. 99 State File No. 156860

(If born in hospital or institution give name.)

Prim. Registration District No. 2177 Local Registrar's No. 731

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>2</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 18 1927</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Argrol

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER

FULL NAME Magnus Robert Wiley

Residence (Usual place of abode) Teton, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 21 (Years)

Birthplace Teton, Idaho (City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Cordelia Bowman

Residence (Usual place of abode) Teton, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 22 (Years)

Birthplace St. Anthony, Idaho (City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 11 P. M.
on the date above stated. Stillborn }

(Signature) P. M. Kelly, M. D.

(Physician or midwife)

Address St. Anthony, Idaho

Filed 1272 19 1927 C. M. Hansen

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF TEXAS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
Birth Registration Number No. _____

NAME OF CHILD

First Name _____
Middle Name _____
Last Name _____
Sex _____
Date of Birth _____
Place of Birth _____

It has been determined that the child was born _____
at _____
on the _____ day of _____
in the year _____.

Signature of Physician _____
Signature of Mother _____
Signature of Father _____
Signature of Registrar _____

CERTIFICATE OF ATTENDING PHYSICIAN OF BIRTH

I hereby certify that I attended the birth of this child who was born _____
on the date above stated.

It was found that the child was born _____
and was _____
at the time of birth.

THIS IS A LEGAL DOCUMENT
AND MUST BE KEPT IN A SAFE PLACE
FOR FUTURE REFERENCE
IT IS THE DUTY OF THE BIRTH REGISTRAR
TO SEE THAT THIS CERTIFICATE IS
CORRECTLY FILLED OUT AND
SUBMITTED TO THE BUREAU OF VITAL STATISTICS
IN A TIMELY MANNER

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE

RECEIVED NOV 18 1927

STATE OF IDAHO

County of Jefferson

DEPARTMENT OF PUBLIC WELFARE

City of Pigley Court

BUREAU OF VITAL STATISTICS

No. 293-222 026-764 St. 2

CERTIFICATE OF BIRTH

Registration District No. 98 State File No. 156925

(If born in hospital or institution give name.)

Prim. Registration District No. 2176 Local Registrar's No. 233

FULL NAME OF CHILD

Stillbirth (7 months)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other? ☒

and

Number
in order
of birth ☒

Legiti-
mate ☒

Date of
birth

Oct. 22, 1927
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 12 (a) Born alive and now living 11

Born alive but now dead 1

Stillborn

FULL
NAME

Sidney Bellman

FATHER

Residence (Usual place of abode)

Pigley Court

If nonresident, give place and State

Color or race

White

Age at last Birthday

47
(Years)

Birthplace

Utah
(City and State or Country)

Occupation

Farmer

FULL
MAIDEN
NAME

Malinda Gough

MOTHER

Residence (Usual place of abode)

Pigley Court

If nonresident, give place and State

Color or race

White

Age at last Birthday

44
(Years)

Birthplace

Utah
(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:45 P. M.
on the date above stated.

(Signature)

M. R. Thet
M. R.

(Physician or midwife)

Address

Pigley Court

Filed

11-1-27 E. J. Farmer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS A PERMANENT RECORD
 IN CASE OF DEATH OF CHILD
 THIS RECORD WILL BE KEPT FOR
 100 YEARS

PLATE
 COUNTY OF
 CITY OF
 No.
 (If born in hospital or institution)
 (If born in hospital or institution)
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CHICAGO, ILL.

Registration District No. 158835
 State File No.
 Local Registration No.
 WILL NAME OF CHILD

Sex of Child
 Date of Birth
 (Day) (Month) (Year)
 (To be answered in event of birth, death, or marriage)

What prophylactic was used to prevent Ophtalmia Neonatorum?
 (a) How alive and how living
 (b) How alive and how dead

Residence (Usual place of abode)
 If nonresident, give place and date
 Color or race
 (Years)

Residence (Usual place of abode)
 If nonresident, give place and date
 Color or race
 (Years)

Residence (Usual place of abode)
 If nonresident, give place and date
 Color or race
 (Years)

Residence (Usual place of abode)
 If nonresident, give place and date
 Color or race
 (Years)

Residence (Usual place of abode)
 If nonresident, give place and date
 Color or race
 (Years)

*Where there was no attending physician or midwife, then the father, householder, etc. should make the return. If the child is one that neither mother nor father was other evidence of birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was
 (Signature)

Address
 Registration

FORM V. S. No. 54-26 M-1-18

RECEIVED NOV 13 1927

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of JeffersonRegistration District No. 98City of RigleyPrimary Registration District No. 2176City of Rigley(No. - St.)File No. 59575Registered No. 157

If death occurs away from usual residence give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillbirth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Oct. 22 1927
(Month) (Day) (Year)

7. AGE

Stillbirth
Yrs. - Mos. - da. -IF LESS than 1 day
how many - hrs.
or - min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Rigley, Idaho.

10. NAME OF FATHER

Sidney Bullman

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Malinda Gough

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

15.

Filed 11-1 27Local Registrar R. L. Kaven

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 22 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 22 1927 to Oct. 22 1927that I last saw him alive on Oct. 22 1927and that death occurred on the date stated above, at - M.

The CAUSE OF DEATH was as follows:

Stillbirth due to toxemia of pregnancy.(Duration) - Yrs. - mos. - da.Contributory
(Secondary)(Duration) - yrs. - mos. - da.

(Signed)

N. P. West M. D.19 -(Address) Rigley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place - In the
of death - yrs. - mos. - days. State - yrs. - mos. - days

Where was disease contracted if not at place of death?

Former or usual residence -

19. PLACE OF BURIAL OR REMOVAL

Utah

DATE OF BURIAL

10/23 1927

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE STAMP HERE

STATE OF IDAHO

S

County of Blaine RECEIVED NOV 21 1927 DEPARTMENT OF PUBLIC WELFARE
City of Idaho BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 249 227 029-713 St.

Registration District No. 65 State File No. 156962

(If born in hospital or institution
give name.)

Prim. Registration District No. 2148 Local Registrar's No.

FULL NAME OF CHILD CLARA EDITH SMITH
not named Infant Smith

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Oct. 27 1927</u> (Month) (Day) (Year)
----------------------------	---	--	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None, still-born

Number of child of this mother, including present birth 3rd (a) Born alive and now living 1

Born alive but now dead 2 Stillborn Both

FATHER FULL NAME <u>Martin Luther Smith</u>	MOTHER FULL MAIDEN NAME <u>Clara E. Patock</u>
--	---

Residence (Usual place of abode) Idaho Residence (Usual place of abode) Idaho

If nonresident, give place and State Idaho If nonresident, give place and State Idaho

Color or race White Age at last Birthday 39 Color or race White Age at last Birthday 36

Birthplace Latth Co. Idaho (City and State or Country) Birthplace Little Rock Ark (City and State or Country)

Occupation Millwright Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3-30 P. M.
on the date above stated. Stillborn

(Signature) W. S. Darr

M. D.
(Physician or midwife)

Address Reliance Wash.

Filed Oct-28-1927 J. M. Thompson

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

ONAH
NEW YORK
DISTRICT

noted and followed

1901
1902

11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH **RECEIVED NOV 21 1927**
 County of **Idaho** Registration District No. **68**
 City of **Onaway** Primary Registration District No. **2141**
 (No. St.)

File No. **59627**
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Smith (not named)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Infant**
 (Write the words)

6. DATE OF BIRTH **Oct 27 1927**
 (Month) (Day) (Year)

7. AGE **still born** IF LESS than 1 day how many hrs. or min. ?
 Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE **Onaway Idaho**
 (State or Country)

10. NAME OF FATHER **Martin Luther Smith**

11. BIRTHPLACE OF FATHER **Idaho Co Idaho**
 (State or Country)

12. MAIDEN NAME OF MOTHER **Clara E Patock**

13. BIRTHPLACE OF MOTHER **Wis**
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Martin Luther Smith**
 (Address) **Onaway Idaho**

15. Filed **Oct-28 1927** **D. J. Thompson**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 27 1927**
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at **9:30 P.M.**
 The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)
 (Duration) Yrs. mos. ds.

(Signed) **W S Darr** M. D.

10-27-27 (Address) **Palouse W I**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Shorncliffe Cemetery** DATE OF BURIAL **Oct 29 1927**

20. UNDERTAKER **Parents** ADDRESS **Palouse**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

155-202-029 859

PLACE OF BIRTH

RECEIVED DEC 1-0 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Moscow

No. 720 So Main St.

Hospital The Gritman

Registration District No. 61

Primary Registration District No. 1011

File No.

156977

Registered No. 129

CERTIFICATE OF BIRTH

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes.

Date of
birth

Nov 2 1927

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth... 2

Number of child of this mother now living, including present birth... 1

FULL
NAME

FATHER

William Chas Jenkins

RESIDENCE

Genesee, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

41

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Bessie Dorothy Herman

RESIDENCE

Genesee, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

29

(Years)

BIRTHPLACE

Idaho

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

William L. Gritman

at 1:45 P. M.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Chas. L. Gritman M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

720 So Main - Moscow Idaho

Filed

Nov 10 1927

W.H. Barithers

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 10 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59643

PLACE OF DEATH

County of Latah

Registration District No. 61

City of MOSCOW

Primary Registration District No. 1011

Local Registrar's No. 73

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Jenkins

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 2, 1927

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) MOSCOW
(State or country)

Idaho

10 NAME OF FATHER

W.C. Jenkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

N. Car.

12 MAIDEN NAME OF MOTHER

Bessie Herman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho

14 Informant W.C. Jenkins

(Address)

MOSCOW

15 Filed Nov 2, 1927 W.H. Carithers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 2, 1927

(Month)

(Day)

19
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 2 1927, to _____, 19____

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn - Cannot determine cause

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Gritman, M. D.

11/2/ 1927 (Address) MOSCOW

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial or Removal

Genesee, Ida.

Date of Burial

11/2/27 19

20. Undertaker

H. R. Short

Address

MOSCOW

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or ~~as~~ probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Lincoln
City of Shoshone
No. 498-213.032593 St. Registration District No. 1016 State File No. 157001
Hospital _____ Primary Registration District No. 2016 Local Registrar's No. 54
FULL NAME OF CHILD Pryden

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth 11-13-1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0
FATHER MOTHER
FULL NAME Thomas M. Pryden Maud Williams
RESIDENCE Shoshone, Idaho Shoshone, Idaho
COLOR white AGE AT LAST BIRTHDAY 36 white AGE AT LAST BIRTHDAY 39
(Years) (Years)
BIRTHPLACE Idaho Idaho
OCCUPATION R.R. Engineer Home wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Nov 14, 1927

J. L. Zuller
Registrar.

(Signature)

E. W. Fox
Physician
(Physician or midwife)

Address

Stanley, Idaho

Filed

192

Registrar.

[REDACTED]

44-38861-101

17-00000

1000

1991

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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M33 AM
9 MAY

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PHILADELPHIA
JAN 19 1919

(continued)

1992

following is a list of the

787410

RECEIVED DEC 12 1927

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of LaramieCity of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1016Primary Registration District No. 2016

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 59647Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Dryden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

11 - 13 1927
(Month) (Day) (Year)

7. AGE

0IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shoshone, Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maud Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. M. Dryden

(Address)

Shoshone, Idaho

15.

Filed Nov. 14 1927J. L. Guller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 - 13 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 / 13 1927 to 11 / 13 1927

that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born 5 mos. prematureCause unknown

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. W. Fox M. D.
11 / 14 1927 (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone, Idaho

19____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OR RECEIVED JAN 5 1928

STATE

County of Bonner
City of Sandpoint
No. 266-221-009-71 St.

DEPARTMENT OF WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Parnell

(If born in hospital or institution
give name.)

Registration District No. 78 State File No. 157453

Prim. Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn Booth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of Birth <u>Dec. 21, 1927</u> (Month) (Day) (Year)
----------------------------	--	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>John Booth</u>	MOTHER FULL MAIDEN NAME <u>Anna Page</u>
---------------------------------------	---

Residence (Usual place of abode) Sandpoint, Ida Sandpoint

If nonresident, give place and State _____

Color or race White Age at last Birthday 32 White Age at last Birthday 30
(Years) (Years)

Birthplace Pullman, Wash. Nez Perce
(City and State or Country) (City and State or Country)

Occupation Principal High School Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive
Stillborn} at 4 P. M.
on the date above stated.

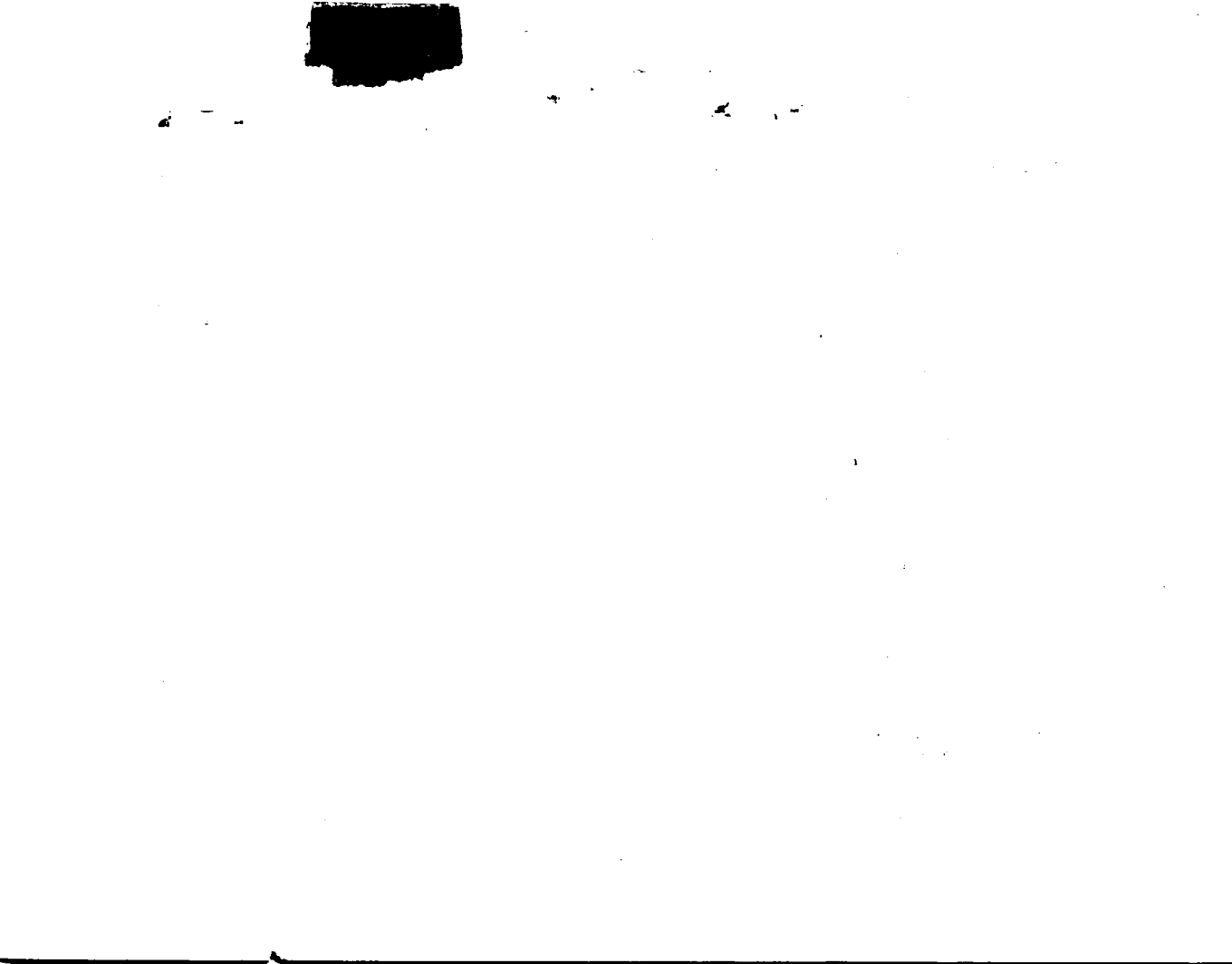
(Signature) Boyd G. Wendt

M. D.
(Physician or midwife)

Address Sandpoint, Ida.

Filed Jan 3 1928 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59870

PLACE OF DEATH

County of Banner
City of Sandpoint

Registration District No. _____
Primary Registration District No. 2155

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Infant Booth

(a) Residence No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Dec. 21, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min. stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Sandpoint Idaho (State or country)

10. NAME OF FATHER John Booth

11. BIRTHPLACE OF FATHER (city or town) Pullman Wash. (State or Country)

12. MAIDEN NAME OF MOTHER Anna Page

13. BIRTHPLACE OF MOTHER (city or town) Neg River Idaho (State or Country)

14. Informant John Booth (Address) Sandpoint, Idaho

15. Filed Dec 23, 1927 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 21, 1927 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

that I last saw him alive on Dec - 21, 1927, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Anti partum haemorrhage and Gestation

CONTRIBUTORY PLACENTA PREVIA (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Play G. Wendle, M. D.

12-24, 1927 (Address) Sandpoint, IDA.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lincrest Cemetery Date of Burial Dec. 23, 1927

20. Undertaker L. H. Moon Address Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

495707 009 7/3
PLACE OF BIRTH
RECEIVED JAN 5 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S

County of Bonner
City of Sandpoint
323 S. Euclid
No. _____ St. Registration District No. 76 State File No. 157459
Hospital Parnell Primary Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD Albert Dreier Jr.
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> } and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 7</u> 192 <u>7</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>9th</u>	Number of child of this mother now living, including present birth <u>8</u>
FATHER FULL NAME <u>Albert Dreier</u> RESIDENCE <u>Sandpoint, Idaho</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>49</u> (Years) BIRTHPLACE <u>Switzerland</u> OCCUPATION <u>Blacksmith</u>	MOTHER FULL MAIDEN NAME <u>Daisy Patrick</u> RESIDENCE <u>Sandpoint, Idaho</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>36</u> (Years) BIRTHPLACE <u>Pocahontas, Virginia</u> OCCUPATION <u>Housewife</u>

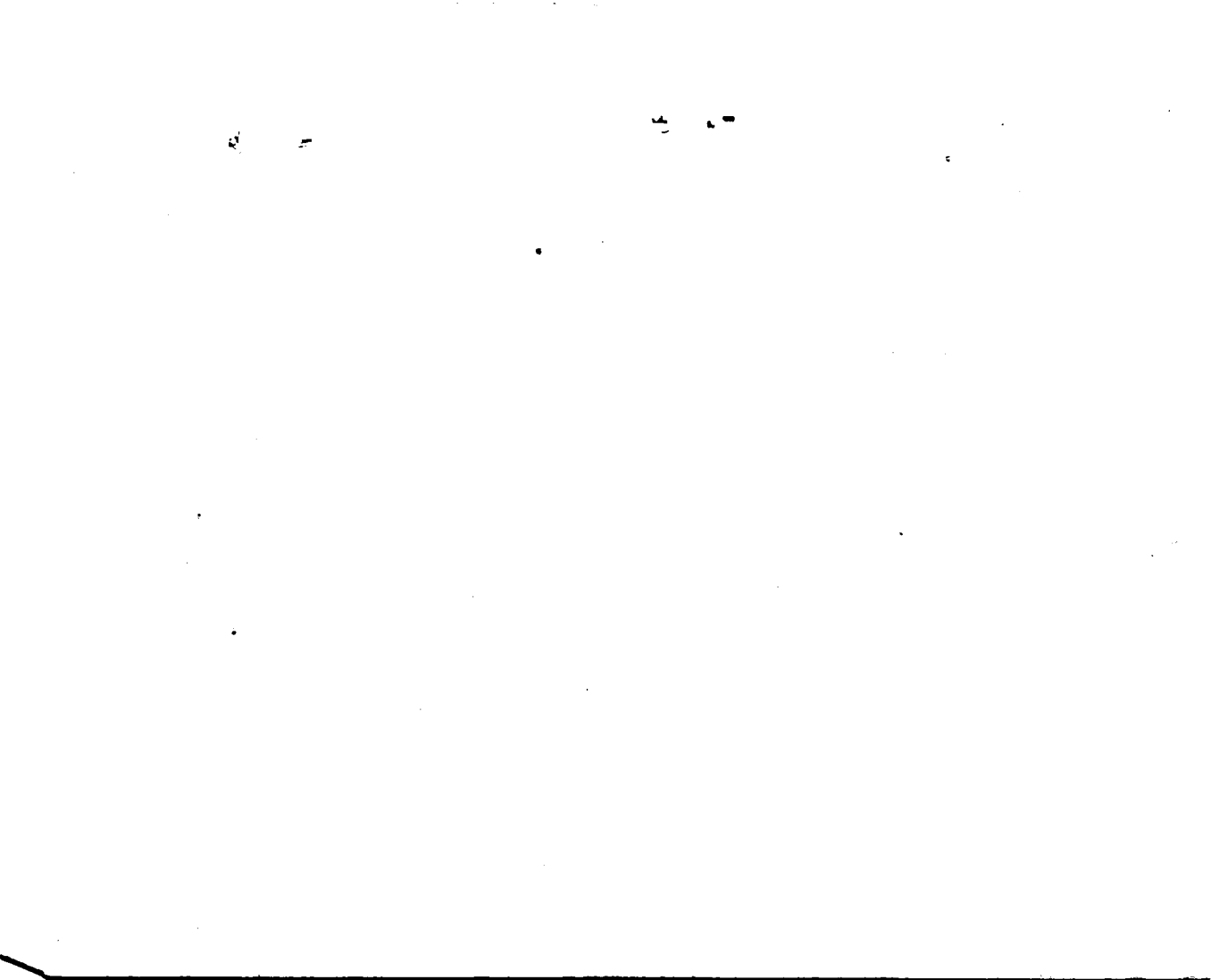
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1927

(Signature) J. B. Wans
Physician
(Physician or midwife)
Address Sandpoint
Filed Jan 3 1928 Viola Allen
Deputy Registrar.



RECEIVED JAN 5 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **59865**

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78Primary Registration District No. 155

Local Registrar's No. _____

(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Dreier(a) Residence. No. 917 Lake Street St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE still birth Years Months Days If LESS than 1 day, min. hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10. NAME OF FATHER Albert Dreier

11. BIRTHPLACE OF FATHER (city or town) Switzerland
(State or Country)

12. MAIDEN NAME OF MOTHER Daisy May Patrick

13. BIRTHPLACE OF MOTHER (city or town) Virginia
(State or Country)

14. Informant Albert Dreier
(Address) 917 Lake St

15. Filed Dec 9, 1927 Viola Allen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8th, 1927, to Dec. 8th, 1927

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:
Stillborn due to
premature detachment of
placenta, 8 1/2 months
gestation. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. D. Gomer, M. D.12-5, 1927 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery Date of Burial Dec 9 1927

20. Undertaker Parnell Co Address Sandpoint, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

157452

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary); may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

258-204-010-866

PLACE OF BIRTH RECEIVED

JAN 5 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bonneville

City of Idaho Falls

No. _____ St.

L. T. S. Hospital
(If born in hospital or institution
give name.)

Registration District No. 73 State File No. 157521

Prim. Registration District No. 2142 Local Registrar's No. 447

FULL NAME OF CHILD Beyer, Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Dec. 4</u> <u>1927</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Beyer, Arthur

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race white Age at last Birthday 41 (Years)

Birthplace Wisconsin

(City and State or Country)

Occupation Pipe fitter

MOTHER
FULL MAIDEN NAME Hoffman, Mary

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race white Age at last Birthday 39 (Years)

Birthplace Germany

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive
Stillborn } at 4:02 P. M.
on the date above stated.

(Signature) _____

(Physician or midwife)

Address Idaho Falls Ids

Filed Dec 7 19 27 C. J. Farnsworth

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ND

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Caribou

City of Hamper

No. 236-110-04 '613

Hospital

St. Registration District No. 7 State File No. 157542

Primary Registration District No. 2006 Local Registrar's No. 521

FULL NAME OF CHILD Joseph Starey

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>X</u> and { Number in order of birth <u>X</u>	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 10</u> 192 <u>7</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Sam Starey
RESIDENCE Hamper Ida
COLOR white AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Ind.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Della Waltrman
RESIDENCE Hamper Ida
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Texas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. H. Murray

(Physician or midwife)

Address Hamper Idaho

Filed 12-21 1927 MacFarley

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

343-125014847
PLACE OF BIRTH

RECEIVED

JAN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Hamlet

CERTIFICATE OF BIRTH

No. St. Registration District No. 7 State File No. 157558

Hospital Mercy Primary Registration District No. 1006 Local Registrar's No. 520

FULL NAME OF CHILD Not named

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>X</u>	and { Number in order of birth <u>X</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Nov 23-1927</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 2

FULL NAME	FATHER
<u>Charles Luthman</u>	
RESIDENCE	<u>Hamlet Ida</u>
COLOR	<u>White</u>
BIRTHPLACE	<u>Iowa</u>
OCCUPATION	<u>Tramster</u>

FULL MAIDEN NAME	MOTHER
<u>Alice Hinghey</u>	
RESIDENCE	<u>Hamlet Ida</u>
COLOR	<u>White</u>
BIRTHPLACE	<u>Ill.</u>
OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

(Signature)

(Physician or midwife)

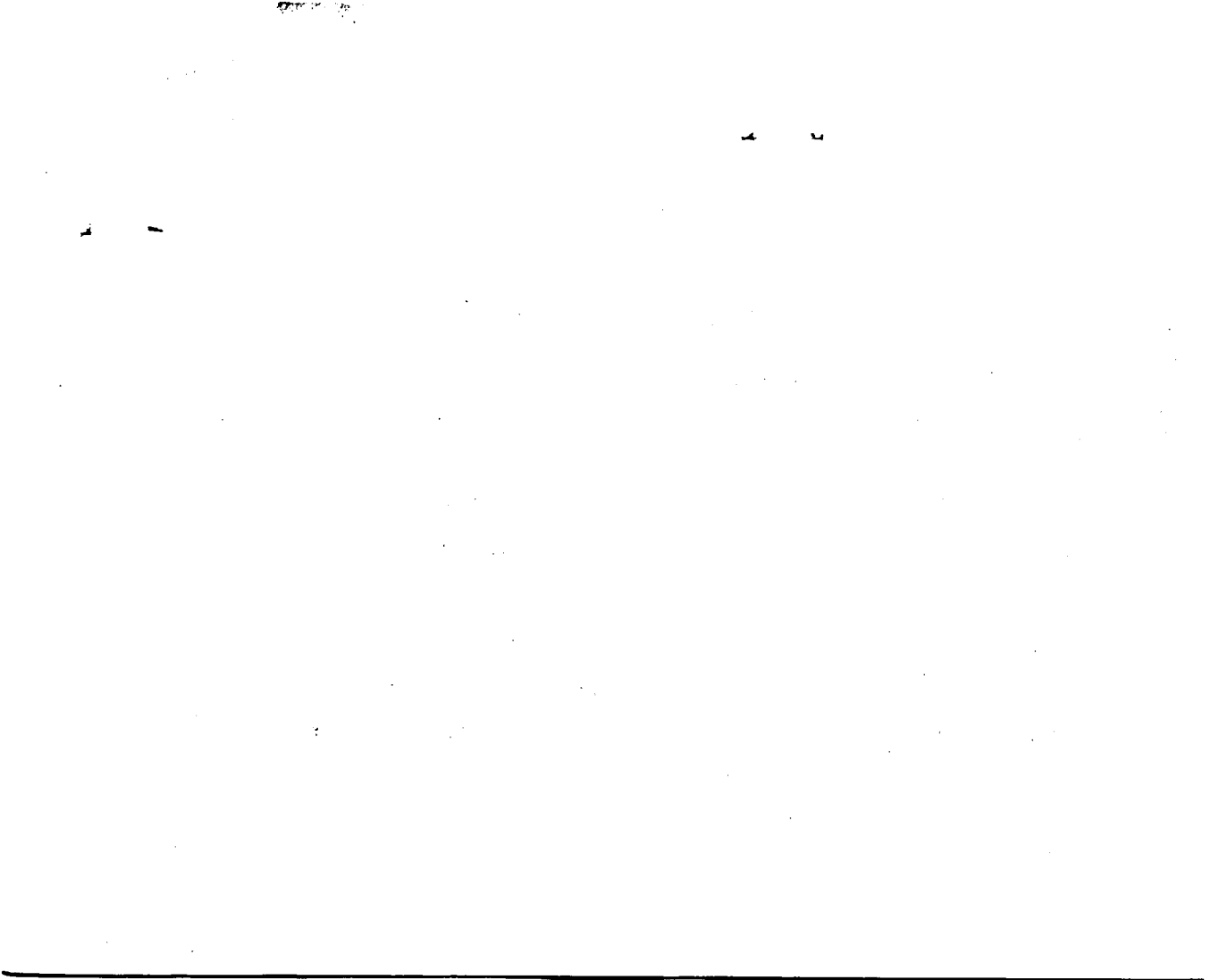
Address

Filed

192.....

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 59537
Registered No. 909

1. PLACE OF DEATH
County of Canyon
City ofampa

Registration District No. 7
Primary Registration District No. 1006
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Nov 25 1927
(Month) (Day) (Year)

7. AGE Still born
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country)ampa Ida.

10. NAME OF FATHER Charles Luttman

11. BIRTHPLACE OF FATHER
(State or Country)Iowa

12. MAIDEN NAME OF MOTHER Alice Hughes

13. BIRTHPLACE OF MOTHER
(State or Country)Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Luttman
(Address)ampa Ida

15. Filed 12-1 1927 Mae Gerber
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 25 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1927 at birth that I last saw him alive on Born dead and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Deformation of head & face. Died in utero.

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) not known

(Signed) J. H. Murray M. D.
11/26 1927 (Address)ampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL at home of parents
DATE OF BURIAL 11/26-1927

20. UNDERTAKER (Father) none ADDRESS ampa Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Adair RECEIVED JAN 3 1928
City of Sada Springs
No. 349-215015266 St.
(If born in hospital or institution give name.)
Registration District No. 82 State File No. 157621
Prim. Registration District No. 2159 Local Registrar's No. 51

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Twins and { Number in order of birth 1 Legitimate? yes Date of birth Dec. 16, 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 2

FATHER	MOTHER
FULL NAME <u>Orval Turner</u>	FULL MAIDEN NAME <u>Clara Hawler</u>
Residence (Usual place of abode) <u>Sada Spgs, Ida</u>	Residence (Usual place of abode) <u>Sada Spgs Ida</u>
If nonresident, give place and State <u>—</u>	If nonresident, give place and State <u>—</u>
Color or race <u>white</u> Age at last Birthday <u>70</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>70</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Rancher</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:30 P. M.
on the date above stated. { Stillborn }

(Signature) Russell Ziegler

(Physician or midwife)

Address Sada Springs, Ida

Filed 12/18 1927 Dr. Russell Ziegler
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Business started to pick up in 1922 for 1921 and was \$1000

*Where there was no attending physician or a written order the father, mother, child, or grandchild may be sworn to as a witness. This is one of the most important provisions of the act and shows clear evidence of its purpose.

(b) (7)(C), (b) (7)(D)

RECEIVED BY THE DIRECTOR OF THE FBI

[illegible]

157081

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED JAN 3 1928
PLACE OF DEATHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59927

County of CaribouCity of Soda SpringsRegistration District No. 87Primary Registration District No. 2159Local Registrar's No. 36(No. —)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Infant Turner(a) Residence. No. — St. —

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) single
- 6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stillborn
6. DATE OF BIRTH (month, day and year) Dec. 16, 1927
7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Soda Springs, Ida.
(State or country)10. NAME OF FATHER Orval Turner11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Clara Bowler13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Clara Turner
(Address) Soda Springs, Idaho15. Filed 12/31, 1927 Dr. Russell Ziegler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Dec. 15, 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1927, to Dec. 16, 1927
that I last saw him alive on Stillborn, 1927
and that death occurred, on the date stated above, at — m.
The CAUSE OF DEATH* was as follows:Stillborn - Cause
undetermined - Time was
less than 40 mins. later alive
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) Russell Ziegler, M. D.
12/16, 1927 (Address) Soda Springs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs, Idaho Date of Burial 12/16, 192720. Undertaker none Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown**.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED JAN 16 1928

PLACE OF BIRTH

County of Clearwater.

City of Orofino, Ida.

No. 256-121-018 995 St.

Orofino, Hosp.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

157676

Registration District No. 90 State File No. 56

Prim. Registration District No. 2168 Local Registrar's No. 56

FULL NAME OF CHILD Unnamed. Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate?	Date of birth		
<u>Male.</u>				<u>Yes.</u>	<u>Dec. 21th.</u>	<u>1927.</u>	
					(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth one (a) Born alive and now living None

Born alive but now dead None Stillborn One.

FATHER

FULL NAME Fred Jesse Knox.

Residence (Usual place of abode) Fraser, Ida.

If nonresident, give place and State _____

Color or race White, Age at last Birthday 30 (Years)

Birthplace Idaho.
(City and State or Country)

Occupation Farmer.

MOTHER

FULL MAIDEN NAME Mikalena Zingerly,

Residence (Usual place of abode) Fraser, Ida.

If nonresident, give place and State _____

Color or race White, Age at last Birthday 24. (Years)

Birthplace N. M.
(City and State or Country)

Occupation House-wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at II:30 A. M.
on the date above stated.

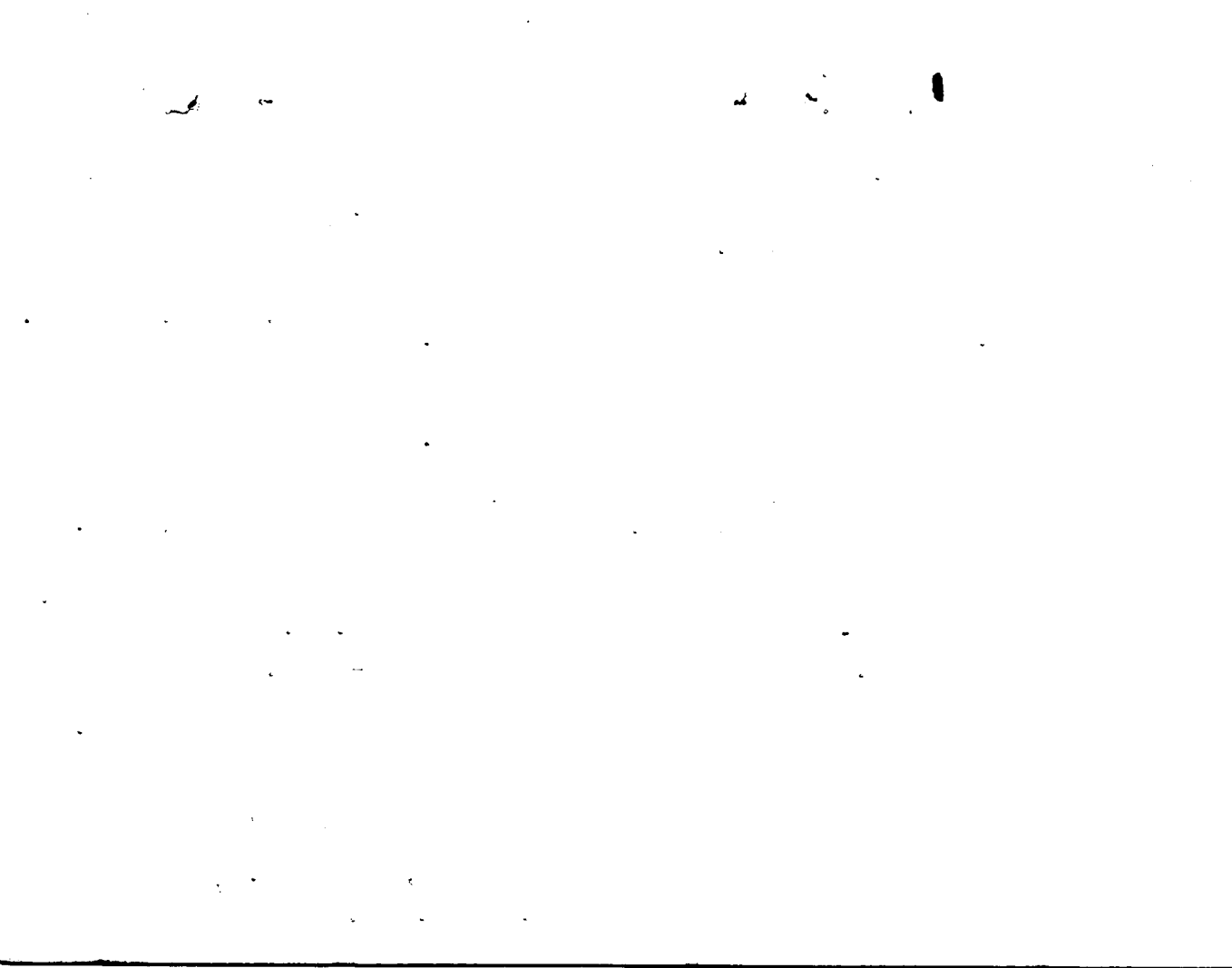
(Signature) J. M. Gentry

Physician.
(Physician or midwife)

Address Orofino, Idaho.

Filed Dec. 29th 27. J. M. Gentry
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 8 20M-1-16-12		JAN 16 1928		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. 90				File No. 59939	
County of Greer		Primary Registration District No. 2168				Registered No. 327	
City of Orofino, Idaho. (No., St.)						If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME Evert Knox					
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH.	
3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WID-OWED OR DIVORCED.		16. DATE OF DEATH	
Male		White		Single (Write the word.)		Dec 21 191 (Month) (Day) (Year)	
6. DATE OF BIRTH						17. I HEREBY CERTIFY, That I attended deceased from	
Dec 21 1927 (Month) (Day) (Year)						December 20, 27 to December 21, 1927,	
7. AGE						that I last saw him alive on 191	
yrs. mos. ds.						and that death occurred on the date stated above, at M.	
IF LESS than 1 day how many hrs. or mins.?						The CAUSE OF DEATH* was as follows:	
8. OCCUPATION						Stillbirth. Delayed delivery.	
(a) Trade, profession or particular kind of work Baby						(Duration) yrs. mos. ds.	
(b) General nature of industry business, or establishment in which employed (or employer)						Contributory High forceps operation. (Secondary)	
9. BIRTHPLACE						(Duration) yrs. mos. ds.	
(State or Country) Orofino Ida						(Signed) M. D.	
10. NAME OF FATHER James Knox						Dec. 31, 27 (Address) Orofino, Idaho.	
11. BIRTHPLACE OF FATHER Ida						*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
(State or Country)						18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)	
12. MAIDEN NAME OF MOTHER May Singlerly						At place of death yrs. mos. days. In the State yrs. mos. days.	
13. BIRTHPLACE OF MOTHER Kanas						Where was disease contracted if not at place of death?	
(State or Country)						Former or usual residence.	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL	
(Informant) James Knox						Orofino Ida Dec. 22, 191	
(Address) Greer Ida						20. UNDERTAKER ADDRESS	
15. Filed December 31, 1927 J. M. Fairly Local Registrar						Orofino, Ia	

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED DEC 14 1927

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Jefferson
City of Rigby
No. 98 St. 11102693

Registration District No. 98 State File No. 157826

Prim. Registration District No. 2126 Local Registrar's No. 346

FULL NAME OF CHILD Stillborn Wren

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other <input type="checkbox"/> (To be answered only in event of plural births)	Number in birth <u>1</u>	Legitimacy <u>leg</u>	Date of birth <u>11 - 11</u> <u>1927</u> (Month) (Day) (Year)
-----------------------	--	--------------------------	-----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 10 (a) Born alive and now living 7

Born alive but now dead 3 Stillborn 1

FATHER FULL NAME <u>Jed Wren</u> Residence (Usual place of abode) <u>Rigby</u> If nonresident, give place and State Color or race <u>W</u> Age at last Birthday (Years) Birthplace <u>Kansas</u> (City and State or Country) Occupation <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Altha Ricks</u> Residence (Usual place of abode) <u>Rigby</u> If nonresident, give place and State Color or race <u>W</u> Age at last Birthday (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ☒ Born alive, ☐ Stillborn at 1:30 9 P. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Rigby

Filed 12-1 1927 [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Placenta Previa

STATE OF CALIFORNIA
 COUNTY OF SAN DIEGO
 VITAL RECORDS
 CERTIFICATE OF BIRTH

81

157880

Investigation District No. _____
 Birth Registration District No. _____

DATE OF BIRTH

At _____, California, on _____ day of _____, 19____

NAME OF CHILD _____
 SEX _____
 COLOR _____
 WEIGHT _____
 LENGTH _____
 HEAD _____
 FEET _____
 FINGER _____
 MIDDLE _____
 RING _____
 PINKY _____
 THUMB _____

Signature of Physician _____

Number of child of this mother, bearing previous birth _____

Place of birth _____

NAME _____

RESIDENCE (Usual place of residence) _____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

At _____, California, on _____ day of _____, 19____

* Where there was an attending physician or midwife, then the father, householder, etc., should make the return. A newborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed _____

(Signature of midwife)

(Signature)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

at _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 14 1927

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59970

County of Jefferson

City of Payson

Registration District No. 18

Primary Registration District No. 2176

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 11-11-27

7. AGE Years Months Days If LESS than 1 day, hrs. or min. 11-11-27

8. OCCUPATION OF DECEASED none

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bigby R.T.D. 3

10. NAME OF FATHER Ed Wren

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Altha Ricks

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14.

Informant. Father
(Address)

15.

Filed 12-1-27

1927

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11-11-27

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-11-27, to 11-11-27

that I last saw him on 11-11-27, 1927

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Stillborn
Placenta previa

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Ricks, M. D.

11-11-27 (address) Payson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sugar City

Date of Burial 11-12 1927

20. Undertaker Love

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Jerome</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Hazelton</u>		BUREAU OF VITAL STATISTICS	
No. <u>493-103 027-791</u>		CERTIFICATE OF BIRTH	
(If born in hospital or institution give name.)		Registration District No. <u>23</u>	State File No. <u>157849</u>
FULL NAME OF CHILD <u>George A. Mickelsen</u>		Prim. Registration District No. <u>2017</u>	Local Registrar's No. <u>15</u>
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate <u>Yes</u>
			Date of birth <u>Oct 3 1927</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>no</u>			
Number of child of this mother, including present birth <u>3</u> (a) Born alive and now living <u>2</u>			
Born alive but now dead _____ Stillborn <u>1</u>			
FATHER FULL NAME <u>Leland Mickelsen</u>		MOTHER FULL MAIDEN NAME <u>Grace Grant</u>	
Residence (Usual place of abode) <u>Hazelton Id</u>		Residence (Usual place of abode) <u>Hazelton Id</u>	
If nonresident, give place and State _____		If nonresident, give place and State _____	
Color or race <u>wh</u> Age at last Birthday <u>32</u> (Years)		Color or race <u>wh</u> Age at last Birthday <u>28</u> (Years)	
Birthplace <u>Utah</u> (City and State or Country)		Birthplace <u>Id</u> (City and State or Country)	
Occupation <u>farmer</u>		Occupation <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive
Stillborn } at 11³⁰-a M.
on the date above stated.

(Signature) E. B. Berry

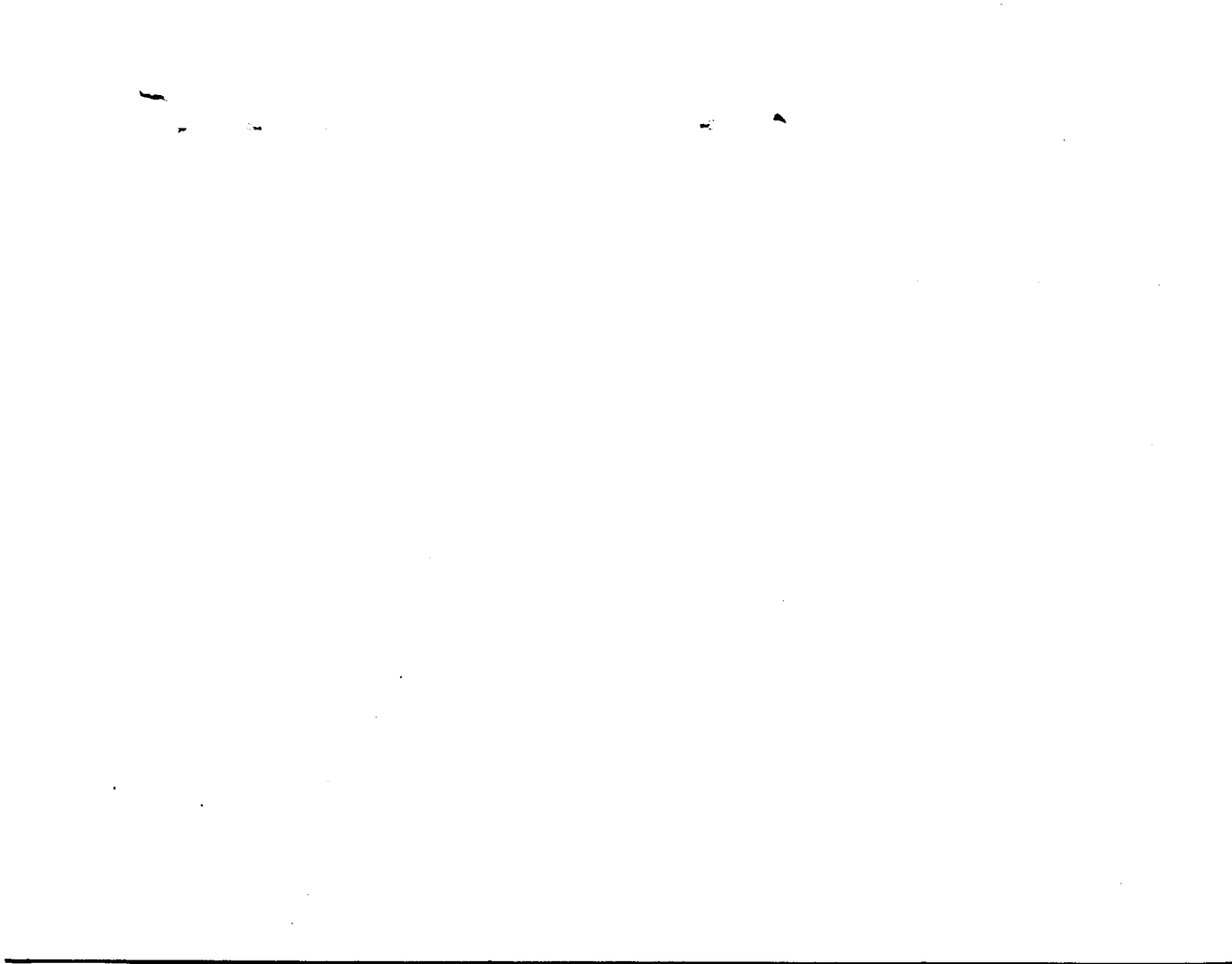
(Physician or midwife)

Address Hazelton

Filed Dec 14 1927

Registrar. E. B. Berry

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 11 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 59975

County of Franklin

Registration District No.

City of Hazelton

Primary Registration District No.

Local Registrar's No. 2

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George A. Mickelson

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Wh

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 3 1927

7 AGE

Years

Months

Days

If LESS than
day or min.

Step 1 year

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Hazelton Ida

10 NAME OF FATHER

Reiland Mickelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Grace Kraus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho

14 Informant

(Address)

Reiland Mickelson
Hazelton

15

Filed

1-8

19

El Barry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 3
(Month) (Day)

1927
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

St. Luke's 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Death in uterus: Probable
same condition of mother
previous

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signature) El Barry, M. D.

Oct 3 1927 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Chinfield Ida

Oct 4 1927

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF

RE

S

County of Lalok

BUREAU OF VITAL STATISTICS

City of Bozill

CERTIFICATE OF BIRTH

No. 39119-09 419 St.Registration District No. 66State File No. 157943Hospital BozillPrimary Registration District No. 148

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Dead before birth (hours)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec. 19</u> , 192 <u>7</u> (Month) (Day) (Year)
--------------------------	-----------------------------------	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME <u>FATHER</u>	FULL MAIDEN NAME <u>MOTHER</u>
<u>Harry E. Bozill</u>	<u>Margaret Martin</u>
RESIDENCE <u>Bozill Idaho</u>	RESIDENCE <u>same</u>
COLOR <u>white</u>	COLOR <u>white</u>
AGE AT LAST BIRTHDAY <u>35</u> (Years)	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Wisconsin</u>	BIRTHPLACE <u>Kansas</u>
OCCUPATION <u>Steam Engineer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidences of life after birth.

(Signature) W. L. P. Ock

(Physician or midwife)

Give names added from a supplemental report.

Address Bozill, IdahoFiled Dec. 23 1927 E. B. Alasher

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

١٠٠

DATE: 10/10/2014

DECLASSIFIED

[illegible]

... and the ...

1990

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains. The *Agrobacterium* strains were grown in the YEA medium for 24 h and then adjusted to the OD₆₀₀ of 0.1. The *Agrobacterium* strains were then grown in the YEA medium with the concentration of 0.1, 0.2, 0.3, 0.4, 0.5, 0.6, 0.7, 0.8, 0.9, 1.0, 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 2.0, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 3.0, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 4.0, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 5.0, 5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 5.9, 6.0, 6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 7.0, 7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, 7.9, 8.0, 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9, 9.0, 9.1, 9.2, 9.3, 9.4, 9.5, 9.6, 9.7, 9.8, 9.9, 10.0, 10.1, 10.2, 10.3, 10.4, 10.5, 10.6, 10.7, 10.8, 10.9, 11.0, 11.1, 11.2, 11.3, 11.4, 11.5, 11.6, 11.7, 11.8, 11.9, 12.0, 12.1, 12.2, 12.3, 12.4, 12.5, 12.6, 12.7, 12.8, 12.9, 13.0, 13.1, 13.2, 13.3, 13.4, 13.5, 13.6, 13.7, 13.8, 13.9, 14.0, 14.1, 14.2, 14.3, 14.4, 14.5, 14.6, 14.7, 14.8, 14.9, 15.0, 15.1, 15.2, 15.3, 15.4, 15.5, 15.6, 15.7, 15.8, 15.9, 16.0, 16.1, 16.2, 16.3, 16.4, 16.5, 16.6, 16.7, 16.8, 16.9, 17.0, 17.1, 17.2, 17.3, 17.4, 17.5, 17.6, 17.7, 17.8, 17.9, 18.0, 18.1, 18.2, 18.3, 18.4, 18.5, 18.6, 18.7, 18.8, 18.9, 19.0, 19.1, 19.2, 19.3, 19.4, 19.5, 19.6, 19.7, 19.8, 19.9, 20.0, 20.1, 20.2, 20.3, 20.4, 20.5, 20.6, 20.7, 20.8, 20.9, 21.0, 21.1, 21.2, 21.3, 21.4, 21.5, 21.6, 21.7, 21.8, 21.9, 22.0, 22.1, 22.2, 22.3, 22.4, 22.5, 22.6, 22.7, 22.8, 22.9, 23.0, 23.1, 23.2, 23.3, 23.4, 23.5, 23.6, 23.7, 23.8, 23.9, 24.0, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 24.7, 24.8, 24.9, 25.0, 25.1, 25.2, 25.3, 25.4, 25.5, 25.6, 25.7, 25.8, 25.9, 26.0, 26.1, 26.2, 26.3, 26.4, 26.5, 26.6, 26.7, 26.8, 26.9, 27.0, 27.1, 27.2, 27.3, 27.4, 27.5, 27.6, 27.7, 27.8, 27.9, 28.0, 28.1, 28.2, 28.3, 28.4, 28.5, 28.6, 28.7, 28.8, 28.9, 29.0, 29.1, 29.2, 29.3, 29.4, 29.5, 29.6, 29.7, 29.8, 29.9, 30.0, 30.1, 30.2, 30.3, 30.4, 30.5, 30.6, 30.7, 30.8, 30.9, 31.0, 31.1, 31.2, 31.3, 31.4, 31.5, 31.6, 31.7, 31.8, 31.9, 32.0, 32.1, 32.2, 32.3, 32.4, 32.5, 32.6, 32.7, 32.8, 32.9, 33.0, 33.1, 33.2, 33.3, 33.4, 33.5, 33.6, 33.7, 33.8, 33.9, 34.0, 34.1, 34.2, 34.3, 34.4, 34.5, 34.6, 34.7, 34.8, 34.9, 35.0, 35.1, 35.2, 35.3, 35.4, 35.5, 35.6, 35.7, 35.8, 35.9, 36.0, 36.1, 36.2, 36.3, 36.4, 36.5, 36.6, 36.7, 36.8, 36.9, 37.0, 37.1, 37.2, 37.3, 37.4, 37.5, 37.6, 37.7, 37.8, 37.9, 38.0, 38.1, 38.2, 38.3, 38.4, 38.5, 38.6, 38.7, 38.8, 38.9, 39.0, 39.1, 39.2, 39.3, 39.4, 39.5, 39.6, 39.7, 39.8, 39.9, 40.0, 40.1, 40.2, 40.3, 40.4, 40.5, 40.6, 40.7, 40.8, 40.9, 41.0, 41.1, 41.2, 41.3, 41.4, 41.5, 41.6, 41.7, 41.8, 41.9, 42.0, 42.1, 42.2, 42.3, 42.4, 42.5, 42.6, 42.7, 42.8, 42.9, 43.0, 43.1, 43.2, 43.3, 43.4, 43.5, 43.6, 43.7, 43.8, 43.9, 44.0, 44.1, 44.2, 44.3, 44.4, 44.5, 44.6, 44.7, 44.8, 44.9, 45.0, 45.1, 45.2, 45.3, 45.4, 45.5, 45.6, 45.7, 45.8, 45.9, 46.0, 46.1, 46.2, 46.3, 46.4, 46.5, 46.6, 46.7, 46.8, 46.9, 47.0, 47.1, 47.2, 47.3, 47.4, 47.5, 47.6, 47.7, 47.8, 47.9, 48.0, 48.1, 48.2, 48.3, 48.4, 48.5, 48.6, 48.7, 48.8, 48.9, 49.0, 49.1, 49.2, 49.3, 49.4, 49.5, 49.6, 49.7, 49.8, 49.9, 50.0, 50.1, 50.2, 50.3, 50.4, 50.5, 50.6, 50.7, 50.8, 50.9, 51.0, 51.1, 51.2, 51.3, 51.4, 51.5, 51.6, 51.7, 51.8, 51.9, 52.0, 52.1, 52.2, 52.3, 52.4, 52.5, 52.6, 52.7, 52.8, 52.9, 53.0, 53.1, 53.2, 53.3, 53.4, 53.5, 53.6, 53.7, 53.8, 53.9, 54.0, 54.1, 54.2, 54.3, 54.4, 54.5, 54.6, 54.7, 54.8, 54.9, 55.0, 55.1, 55.2, 55.3, 55.4, 55.5, 55.6, 55.7, 55.8, 55.9, 56.0, 56.1, 56.2, 56.3, 56.4, 56.5, 56.6, 56.7, 56.8, 56.9, 57.0, 57.1, 57.2, 57.3, 57.4, 57.5, 57.6, 57.7, 57.8, 57.9, 58.0, 58.1, 58.2, 58.3, 58.4, 58.5, 58.6, 58.7, 58.8, 58.9, 59.0, 59.1, 59.2, 59.3, 59.4, 59.5, 59.6, 59.7, 59.8, 59.9, 60.0, 60.1, 60.2, 60.3, 60.4, 60.5, 60.6, 60.7, 60.8, 60.9, 61.0, 61.1, 61.2, 61.3, 61.4, 61.5, 61.6, 61.7, 61.8, 61.9, 62.0, 62.1, 62.2, 62.3, 62.4, 62.5, 62.6, 62.7, 62.8, 62.9, 63.0, 63.1, 63.2, 63.3, 63.4, 63.5, 63.6, 63.7, 63.8, 63.9, 64.0, 64.1, 64.2, 64.3, 64.4, 64.5, 64.6, 64.7, 64.8, 64.9, 65.0, 65.1, 65.2, 65.3, 65.4, 65.5, 65.6, 65.7, 65.8, 65.9, 66.0, 66.1, 66.2, 66.3, 66.4, 66.5, 66.6, 66.7, 66.8, 66.9, 67.0, 67.1, 67.2, 67.3, 67.4, 67.5, 67.6, 67.7, 67.8, 67.9, 68.0, 68.1

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100-443887-100

• *Journal of the American Medical Association*, 1997; 277: 1001-1005

[illegible]

1. *Journal of the American Medical Association*, 2000; 283: 2686-2692.

FORM V. S. No. 5-25 M-1-10

RECEIVED

JAN 5 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 60024

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Idaho

City of Borville

Registration District No. 66

Primary Registration District No. 2148

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Dec. 19 1927
(Month) (Day) (Year)

7. AGE

Born dead

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Borville, Idaho

10. NAME OF FATHER

Harry L. Braine

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Margaret Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry L. Braine
Borville, Idaho

15.

Filed DEC. 23 1927

E. B. Glasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 19 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Born dead - few deadfishes.
Mother eclamptic
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Shook

M. D.

19

(Address)

Borville, Idaho

*State the illness causing death; or in deaths from violent causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 5 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Latah

City of Potlatch

No. _____ St. _____

432-208-029-212

(If born in hospital or institution
give name.)

Registration District No. 65 State File No. 157959

Prim. Registration District No. 2145 Local Registrar's No. _____

FULL NAME OF CHILD Unnamed baby of Donald McKuney

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <input checked="" type="checkbox"/> and <input type="checkbox"/> Number in order of birth <input checked="" type="checkbox"/>	Legitimate? <u>yes</u>	Date of birth <u>Dec. 8th 1927</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living none

Born alive but now dead ☒ Stillborn 0

FATHER
FULL NAME Donald McKuney

MOTHER
FULL MAIDEN NAME Ruth Babb

Residence (Usual place of abode) Potlatch

Residence (Usual place of abode) Potlatch

If nonresident, give place and State ✓

If nonresident, give place and State ✓

Color or race white Age at last Birthday 23
(Years)

Color or race white Age at last Birthday 17
(Years)

Birthplace Minnesota
(City and State or Country)

Birthplace Colfax - Wash
(City and State or Country)

Occupation Lumberman

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 8³⁰ A. M.
on the date above stated.

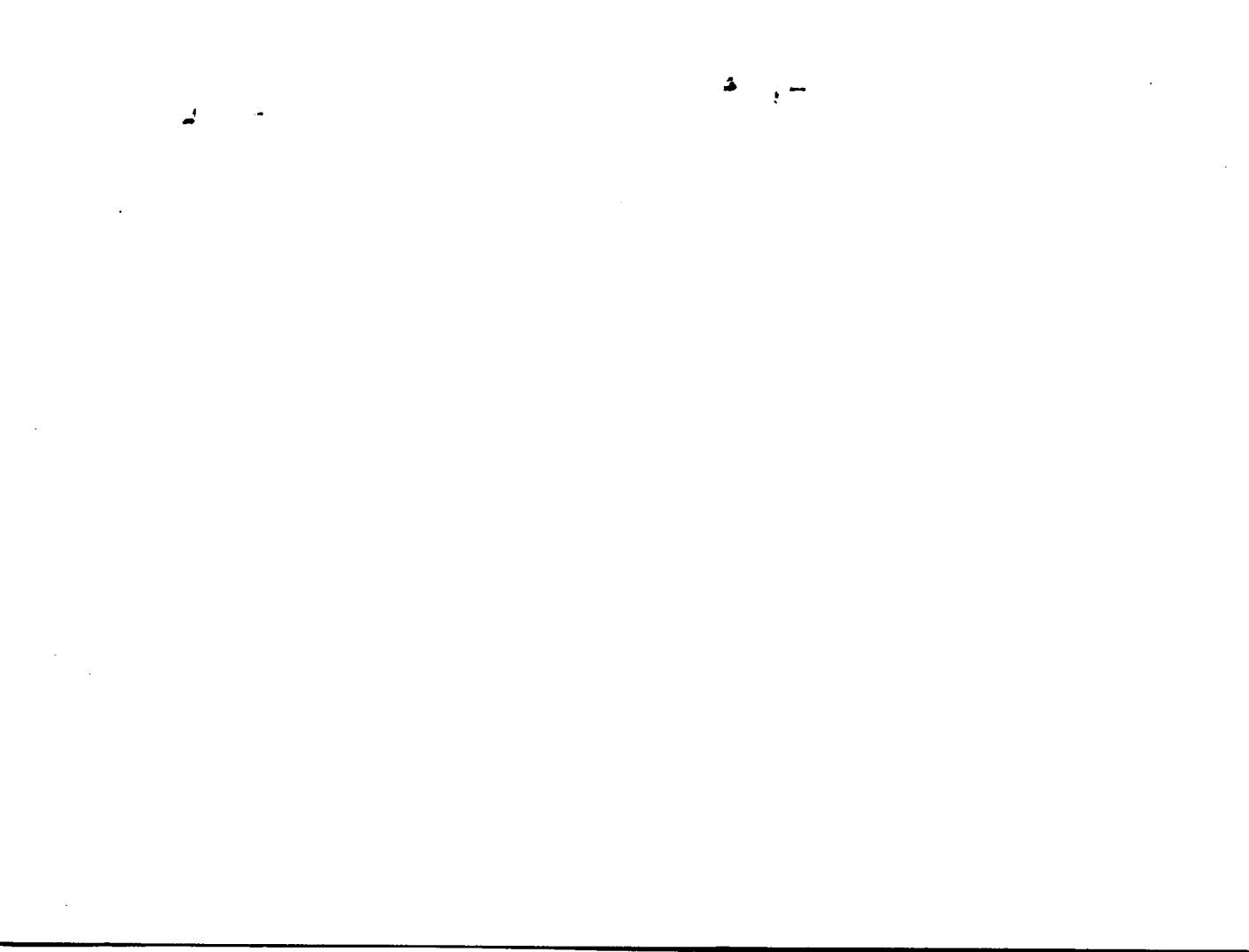
(Signature) D. J. W. Thompson

(Physician or midwife)

Address Potlatch

Filed Dec. 19th 1927 D. J. W. Thompson
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JAN 5 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Idaho
City of BoothRegistration District No. 65
Primary Registration District No. 2145
(No. St.)File No. 60019
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed baby of Donald M. Kinney
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white single
(Write the word.)

6. DATE OF BIRTH

Dec. 8 8 1927
(Month) (Day) (Year)

7. AGE

1 ✓ ✓ ✓
Yrs. Mos. ds. or min. ?
IF LESS than 1 day how many hrs. or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Donald M. Kinney

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Ruth Babb

13. BIRTHPLACE OF MOTHER

(State or Country)

Gulfport Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Donald M. Kinney(Address) Booth

15.

Filed Dec. 19 1927 Dr. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19 to ✓ 19
that I last saw h. ✓ alive on ✓ 19
and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH* was as follows:

Still born.(Duration) ✓ Yrs. mos. ds.Contributory
(Secondary)(Duration) ✓ yrs. mos. ds.(Signed) J. W. Thompson M. D.12/19/1927 (Address) Booth

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Booth Cemetery

DATE OF BURIAL

Dec. 8 1927

20. UNDERTAKER

Parents

ADDRESS

Booth

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED**

County of Litch
City of Pottatch

No. _____ St. _____

714-205-029466
(If born in hospital or institution
give name.)

Registration District No. 65 State File No. 157965

Prim. Registration District No. 2145 Local Registrar's No. _____

FULL NAME OF CHILD - Unamed premature babe of Hazel G. Gaucher
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <input type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input type="checkbox"/> (To be answered only in event of plural births)	and { Number in order of birth <input checked="" type="checkbox"/> }	Legitimate? <u>yes</u>	Date of birth <u>Dec. 5th</u> 19 <u>27</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn _____

FATHER
FULL NAME Ulrich Gaucher
Residence (Usual place of abode) Pottatch
If nonresident, give place and State ✓
Color or race white Age at last Birthday 27 (Years)
Birthplace France
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Hazel G. Moore
Residence (Usual place of abode) Pottatch
If nonresident, give place and State ✓
Color or race white Age at last Birthday 20 (Years)
Birthplace Minnesota (Brainerd)
(City and State or Country)
Occupation Housewife

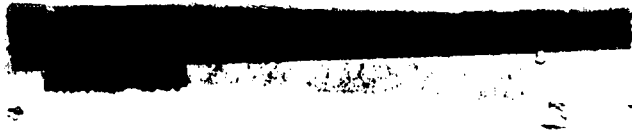
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive ✓ at Stillborn ✓ on the date above stated. 4 = 4 M.

(Signature) D. J. W. Thompson
M. D.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Pottatch
Filed Dec-12 19 27 D. J. W. Thompson
Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE **RECEIVED DEC 15 1927**
 County of Latuh Registration District No. 55
 City of Pottlatch Primary Registration District No. 2145
 (No. _____ St.)

File No. 60012
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed baby of Hayle G. Encher
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

Dec 5th 1927
 (Month) (Day) (Year)

7. AGE

Yrs. ✓ Mos. ✓ ds. ✓ IF LESS than 1 day how many ✓ hrs. or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Pottlatch

10. NAME OF FATHER

Wick Encher

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Hayle G. Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Jenner
 (Address) Pottlatch

15.

Filled Dec - 6th 1927 D. W. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5th 1927
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 5 1927 to Dec 5th 1927

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still - born -

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Thompson M. D.

12/5/1927 (Address) Pottlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Pottlatch Cemetery

DATE OF BURIAL

Dec 5th 1927

20. UNDERTAKER

Parents

ADDRESS

Pottlatch

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

466-131029-466
PLACE OF BIRTH

RECEIVED

JAN 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of Moscow

CERTIFICATE OF BIRTH
157977

No. _____ St. Registration District No. 61 State File No. _____
Hospital _____ Primary Registration District No. 101 Local Registrar's No. 145

FULL NAME OF CHILD Frank Moore
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 31</u> 192 <u>7</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Wesley John Moore
RESIDENCE Moscow Ids.
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Idaho
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Loy Bessie Moore
RESIDENCE Moscow Ids.
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1928

(Signature) John Embury
Physician
(Physician or midwife)

Address _____

Filed Jan 4 1928 W.H. Carothers
Registrar.

Registrar.

11-11-11

11-11-11

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59308

Local Registrar's No. 71

RECEIVED NOV 10 1927
BUREAU OF DEATH
LATAH

CERTIFICATE OF DEATH

County of LATAH Registration District No. 61
City of MOSCOW RD Primary Registration District No. 2141
(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME FRANK MCCRE

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) OCT 31 1927/

7 AGE Years Months Days 1 If LESS than day, hrs. or min. Stillbirth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) MOSCOW
(State or country) Idaho

10 NAME OF FATHER WESLEY MCCRE

11 BIRTHPLACE OF FATHER (city or town) IDAHO
(State or country)

12 MAIDEN NAME OF MOTHER IVY MCCRE

13 BIRTHPLACE OF MOTHER (city or town) KANSAS
(State or country)

14 Informant WESLEY MCCRE
(Address) MOSCOW IDAHO

15 Filed OCT 31 1927 W. H. Carithers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 31 1927
(Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from Oct. 31 1927, to Oct. 31 1927

that I last saw him alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillbirth
Baby had evidently been dead
3 or 4 days before born
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Emberson, M. D.

10/31/1927 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

19 Place of Burial, Cremation, or Removal Date of Burial
Moscow 10/31 1927

20. Undertaker Address
H. R. Short Moscow

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

815-124035-194
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Hyperion RECEIVED JAN 1 1928
City of Leavittston
No. 1504 Main St. Registration District No. 96 State File No. 158103
Hospital White Primary Registration District No. 1009 Local Registrar's No. S
FULL NAME OF CHILD Still Born. No Name Given

(Certificate of no value without full name of child)
Sex of Child Male Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth 12-24 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>David B. Harnif</u>	FULL MAIDEN NAME	<u>Gladys Armstrong</u>
RESIDENCE	<u>Leavittston Idaho</u>	RESIDENCE	<u>Leavittston Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>36</u> (Years)	AGE AT LAST BIRTHDAY	<u>33</u> (Years)
BIRTHPLACE	<u>Iowa</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Salesman</u>	OCCUPATION	<u>House Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 1:30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. L. White

(Physician or midwife)
Address Leavittston
Filed Jan 7 1928 Brian E Bruce
Registrar. Registrar.

1-1-1

"

"

"

"

.

.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 13 1928
PLACE OF DEATH

County of Nez Perce
City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District-No. 96
Primary Registration District No. 1009
(No. White Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Stillborn Hamil.

(a) Residence. No. 812 6th, Avenue. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12/23/27.

7 AGE Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

10 NAME OF FATHER D. B. Hamil.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Armstrong.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho.

14 Informant R. B. Wammi
(Address) Lewiston, Idaho.

15 Filed Jan 28, 1928 Susan E Bruce
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 60065

Local Registrar's No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
December 23rd, 1927.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd, 1927, to Dec 24, 1927, that I last saw him alive on Still born, 1927, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Unknown. Still born.

(duration) yrs. mos. ds.
CONTRIBUTORY No apparent Cause
(Secondary) was dead at least 36 hours before
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. White, M. D.
12/23/27, 1927 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
Lewiston, Idaho. 12/24/27. 19

20. Undertaker Address
Brower-Tann Company. Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

S

158132

County of Oneida RECEIVED JAN 5 1927 DEPARTMENT OF PUBLIC WELFARE
City of Malad BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 386-219-036-795 St.Registration District No. 26 State File No. _____(If born in hospital or institution
give name.)Prim Registration District No. 2069 Local Registrar's No. 184FULL NAME OF CHILD Steel birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>12-19-1927</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none silverNumber of child of this mother, including present birth 9 (a) Born alive and now living 7Born alive but now dead one Stillborn oneFATHER
FULL NAME David P. ThomasMOTHER
FULL MAIDEN NAME Mary PierceResidence (Usual place of abode) MaladResidence (Usual place of abode) Malad

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 39 (Years)Color or race white Age at last Birthday 38 (Years)Birthplace Malad, Ida (City and State or Country)Birthplace Malad (City and State or Country)Occupation FarmerOccupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4:30 A M.
on the date above stated.(Signature) D. M. Kerns

(Physician or midwife)

Address Malad, IdaFiled 12-31-1927 D. M. Kerns

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

128132

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____ State _____
Local Registrar's No. _____

CHILD NAME OF CHILD

Sex of Child _____ Date of Birth _____
Month _____ Year _____

Was any medicine used to prevent (Chloroform) / chloroform? _____
If so, of what kind? _____

Place of birth _____
Is mother alive and now living? _____
If not, when and where did she die? _____

Place of birth _____
Is mother alive and now living? _____
If not, when and where did she die? _____

Color of hair _____
Color of eyes _____
Height _____

Weight _____
Circumference _____
Date of birth _____

Signature of attending physician or midwife _____
Date _____

Signature of mother _____
Date _____

Address _____
City _____

It is the duty of the attending physician or midwife to make a full and accurate record of the birth of every child. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Malad **RECEIVED JAN 5 1928** Registration District No. 2069
City of Malad (No. _____) St. _____

File No. 60072
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chil Bern

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

FemaleWhiteChild
(Write the word.)

6. DATE OF BIRTH

Dec - 19 1927
(Month) (Day) (Year)

7. AGE

Yrs. 1 mo. 11 ds.

IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9. BIRTHPLACE

(State or Country)

Malad clda.

10. NAME OF FATHER

David P. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Malad clda.

12. MAIDEN NAME OF MOTHER

Mary M. Pierce

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad clda.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

David P. Thomas

15.

Filed

12/301927

J. M. Kern
Local Registrar

16. DATE OF DEATH

Dec - 19 1927
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Malad clda. Dec 17 1927
that I last saw h. alive on Dec 13 1927
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Unknown
was born dead.
at home of father.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) J. M. Kern M. D.

19 1927 (Address) Malad clda.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death.....Yrs.....mos.....days State.....Yrs.....mos.....days

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad clda.Dec 19 1927

20. UNDERTAKER

ADDRESS

Guy BensonMalad clda.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

142-221036-319
PLACE OF BIRTH,

RECEIVED JAN 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida

City of Juniper

No. _____ St. _____

Registration District No. 26

State File No. 158133

Hospital _____

Primary Registration District No. 2069

Local Registrar's No. 185-

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Dec 21

1927

(Month) (Day) (Year)

What bactericidal solution was used in eyes? Shell broth

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth none

FULL
NAME

Matthew's Ella Austin

RESIDENCE

Juniper Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

30
(Years)

BIRTHPLACE

Dayton Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

Louisa Ruth Parkin

RESIDENCE

Juniper Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

27
(Years)

BIRTHPLACE

Snowville

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated. Signature

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Chas. H. Hargrave
Chas. H. Hargrave
(Physician or midwife)

Address

Snowville Idaho

Filed

12-30 1927

Registrar.

Registrar.

APR 23 1998

SEP 5 1998

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 5 1928

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Oneida

Primary Registration District No.

City of Juniper

(No. St.)

File No. 60074
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby - Austin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Dec 31 1927
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
P min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Juniper Idaho

10. NAME OF FATHER

Matthews Wells Austin

11. BIRTHPLACE OF FATHER

(State or Country)

Dayton Idaho

12. MAIDEN NAME OF MOTHER

Lynna Ruth Larkin

13. BIRTHPLACE OF MOTHER

(State or Country)

Snowville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Matthews W. Austin
Juniper Idaho

15.

Filed 12/311927J. M. Kins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1927 to Dec 21 1927that I last saw h. lx alive on Still Birth 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature
Still birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/31 1927 (Address) Snowville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Juniper Idaho12/22 1927

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
413 225-038-219
RECEIVED JAN 4 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
County of Payette
City of _____
Certificate of Birth
No. _____ St. Registration District No. 4 State File No. 158144
Hospital _____ Primary Registration District No. 1008 Local Registrar's No. 91
FULL NAME OF CHILD Unnamed (Stillborn)
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 25/27 192</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 5

FATHER	MOTHER
FULL NAME <u>O.Z. Matthews</u>	FULL MAIDEN NAME <u>Etta Barker</u>
RESIDENCE <u>Payette County.</u>	RESIDENCE <u>Payette County.</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>31</u> (Years)	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Oregon</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive Stillborn { 8:00 a. M.
on the date above stated. { Stillborn {

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J.C. Woodward

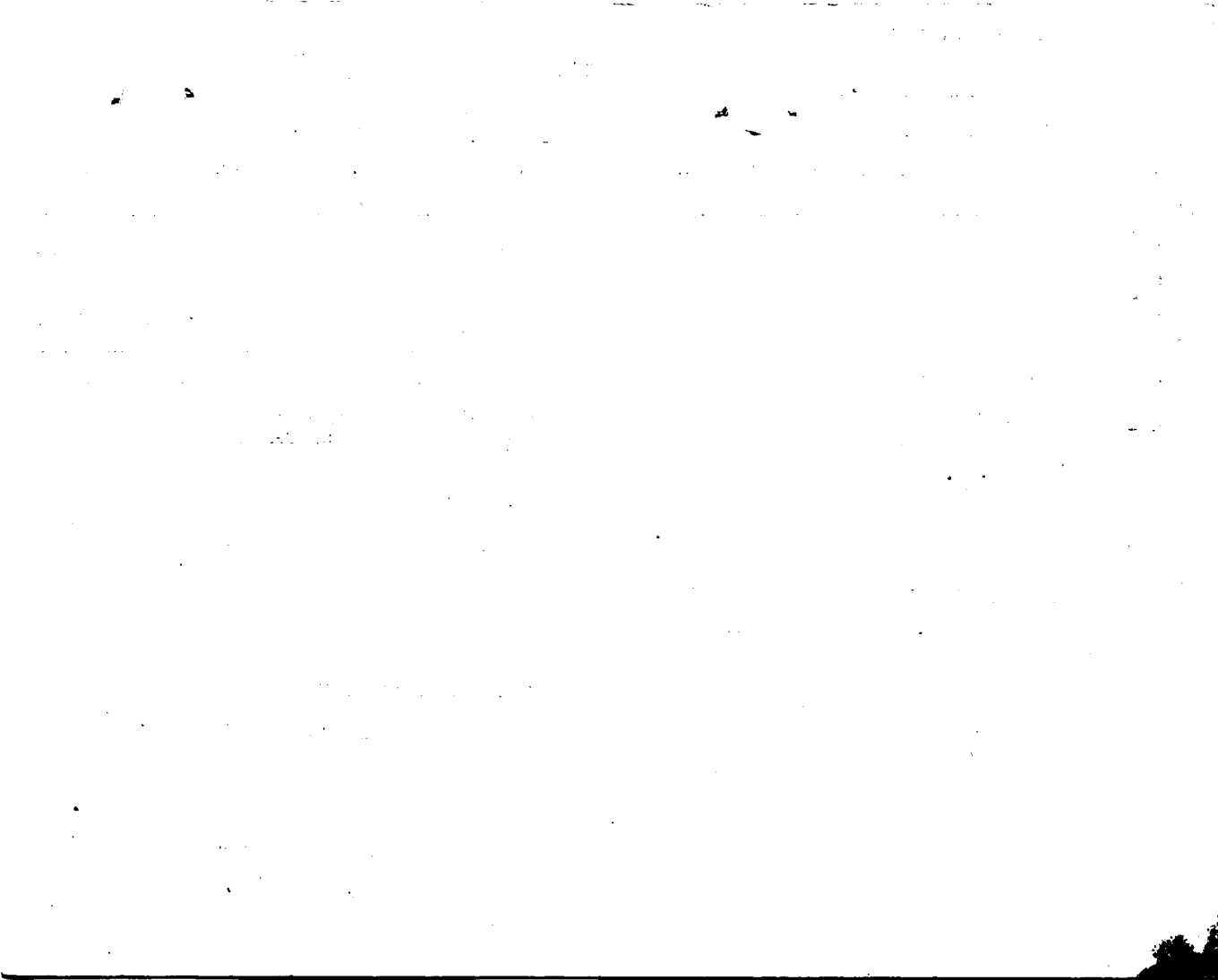
Physician
(Physician or midwife)

Address Payette, Idaho

Filed Dec. 26 1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60086

PLACE OF DEATH

County of Payette.

City of

Registration District No. 4Primary Registration District No. 1008Local Registrar's No. 22

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Infant of O.Z. Matthews.(a) Residence. No. Payette County St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6. DATE OF BIRTH (month, day and year) Dec. 25, 1927

7. AGE Years Months Days If LESS than 1 day, hrs. or min. -----

8. OCCUPATION OF DECEASED Infant

(a) Trade, profession, or particular kind of work -----

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer -----

9. BIRTHPLACE (city or town) Payette County.
(State or country)10. NAME OF FATHER O.Z. Matthews.11. BIRTHPLACE OF FATHER (city or town) Missouri.
(State or Country)12. MAIDEN NAME OF MOTHER Etta Barker13. BIRTHPLACE OF MOTHER (city or town) Oregon
(State or Country)14. Informant J.C. Woodward, M.D.
(Address) Payette, Idaho15. Filed Dec. 26, 19 27 J.C. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 25, 1927
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1927, 19, to Dec. 25, 1927, 19,that I last saw her alive on -----, 19, and that death occurred, on the date stated above, at 5.00 a.m.

The CAUSE OF DEATH* was as follows:

UNKNOWN. Stillborn infant.

(duration) ----- yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) ----- yrs. mos. ds.

18. Where was disease contracted
if not at place of death? -----

Did an operation precede death? ----- Date of -----

Was there an autopsy? -----

What test confirmed diagnosis? -----

12/26/27 (Signed) Payette, Idaho M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette County Date of Burial Dec. 25 192720. Undertaker O.Z. Matthews Address Payette, Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

315 120-028993
PLACE OF BIRTH RECEIVED JAN 6 1928
County of Shoshone STATE OF IDAHO
City of Kellogg DEPARTMENT OF PUBLIC WELFARE
No. 200 St. Premier BUREAU OF VITAL STATISTICS
Hospital St. Luke's Registration District No. 123 State File No. 158178
Primary Registration District No. 220 Local Registrar's No. 135
FULL NAME OF CHILD Lance

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? no and { Number in order of birth 1 Legitimate? yes Date of birth 11/30/1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 1

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Roy Brink</u>	<u>Lance</u>	<u>Helene</u>	<u>Kyrtle Ristman</u>
<u>RESIDENCE</u>	<u>Kellogg, Idaho</u>	<u>RESIDENCE</u>	<u>Kellogg, Idaho</u>
<u>COLOR</u>	<u>White</u>	<u>COLOR</u>	<u>White</u>
<u>BIRTHPLACE</u>	<u>WY.</u>	<u>BIRTHPLACE</u>	<u>Idaho</u>
<u>OCCUPATION</u>	<u>Miner</u>	<u>OCCUPATION</u>	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

A. J. Wadsworth
Physician
(Physician or midwife)

Address

Kellogg, Idaho

Filed

Dec 30 1927

Miss Helen M. Bunde

Registrar.

Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE BIRTH RECORD ACT, 1909, AND THE BIRTH RECORD ACT, 1911, AND THE BIRTH RECORD ACT, 1913, AND THE BIRTH RECORD ACT, 1915, AND THE BIRTH RECORD ACT, 1917, AND THE BIRTH RECORD ACT, 1919, AND THE BIRTH RECORD ACT, 1921, AND THE BIRTH RECORD ACT, 1923, AND THE BIRTH RECORD ACT, 1925, AND THE BIRTH RECORD ACT, 1927, AND THE BIRTH RECORD ACT, 1929, AND THE BIRTH RECORD ACT, 1931, AND THE BIRTH RECORD ACT, 1933, AND THE BIRTH RECORD ACT, 1935, AND THE BIRTH RECORD ACT, 1937, AND THE BIRTH RECORD ACT, 1939, AND THE BIRTH RECORD ACT, 1941, AND THE BIRTH RECORD ACT, 1943, AND THE BIRTH RECORD ACT, 1945, AND THE BIRTH RECORD ACT, 1947, AND THE BIRTH RECORD ACT, 1949, AND THE BIRTH RECORD ACT, 1951, AND THE BIRTH RECORD ACT, 1953, AND THE BIRTH RECORD ACT, 1955, AND THE BIRTH RECORD ACT, 1957, AND THE BIRTH RECORD ACT, 1959, AND THE BIRTH RECORD ACT, 1961, AND THE BIRTH RECORD ACT, 1963, AND THE BIRTH RECORD ACT, 1965, AND THE BIRTH RECORD ACT, 1967, AND THE BIRTH RECORD ACT, 1969, AND THE BIRTH RECORD ACT, 1971, AND THE BIRTH RECORD ACT, 1973, AND THE BIRTH RECORD ACT, 1975, AND THE BIRTH RECORD ACT, 1977, AND THE BIRTH RECORD ACT, 1979, AND THE BIRTH RECORD ACT, 1981, AND THE BIRTH RECORD ACT, 1983, AND THE BIRTH RECORD ACT, 1985, AND THE BIRTH RECORD ACT, 1987, AND THE BIRTH RECORD ACT, 1989, AND THE BIRTH RECORD ACT, 1991, AND THE BIRTH RECORD ACT, 1993, AND THE BIRTH RECORD ACT, 1995, AND THE BIRTH RECORD ACT, 1997, AND THE BIRTH RECORD ACT, 1999.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IOWA

CERTIFICATE OF BIRTH

County of _____
City of _____
No. _____
Registration District No. _____ State File No. _____
Hospital _____
Primary _____
Local Registrar's No. _____

FULL NAME OF CHILD

Sex of _____
Date of _____
Time of _____
Place of _____
Manner of _____
Cause of _____
Place of _____
Manner of _____
Cause of _____

What bactericidal solution was used in _____

Number of child of this mother, including present birth _____
Number of child of this mother, including present birth _____

FATHER FULL NAME _____
MOTHER FULL NAME _____

FATHER RESIDENCE _____
MOTHER RESIDENCE _____

FATHER COLOR _____
MOTHER COLOR _____

FATHER AGE AT LAST BIRTHDAY _____
MOTHER AGE AT LAST BIRTHDAY _____

FATHER BIRTHPLACE _____
MOTHER BIRTHPLACE _____

FATHER OCCUPATION _____
MOTHER OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
On the date above stated.

*When there was no attending physician or midwife, then the father, grandfather, etc., should make this return, a statement that in one that neither parent nor child shows other evidence of life after birth.

Give names asked from a supplemental report.

Physician or midwife _____
Address _____

Physician or midwife _____
Address _____

Physician or midwife _____
Address _____

Physician or midwife _____
Address _____

RECEIVED FEB 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **60426**Local Registrar's No. **1**

PLACE OF DEATH

County of Shoshone
City of KelloggRegistration District No. 123Primary Registration District No. 1281(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Lance

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Nov 29 - 277 AGE Years Months Days 2 LESS than day hrs. min. Still

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Ray Lance11 BIRTHPLACE OF FATHER (city or town) (State or country) Springfield Wash12 MAIDEN NAME OF MOTHER Maude Erickson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bozeman Id14 Informant Ray Lance
(Address) Kellogg Id15 Filed Jan 15 19 28 Mrs Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 20 19 27
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from 11/20/1927 to 11/20/1927
that I last saw him and still with. 19 27
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Death occurred in uterus
a few days before delivery.
6 1/2 mo. fetus.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? ☒

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) A. S. Macdonnell M. D.11/22/1927 (Address) Kellogg Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Greenwood Nov 21, 1927

20. Undertaken Address

R. O. Stuart Kellogg Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACED IN RECEIVED DEPT. OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Washington
City of Krusin
No. 259-225 04495 St. Registration District No. 16 State File No. 158306
Hospital..... Primary Registration District No. 2117 Local Registrar's No. 37
FULL NAME OF CHILD Keith

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 25</u> , 192 <u>7</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? 1

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FULL NAME <u>Elmer M. Keith</u>	FATHER	FULL MAIDEN NAME <u>Lorene Randall</u>	MOTHER
RESIDENCE <u>Durkee Ave</u>		RESIDENCE <u>Durkee Ave</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Ray Co. Mo</u>		BIRTHPLACE <u>Buick Co</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive 6 P at M. on the date above stated. Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

G.M. Halerhauer
Physician
(Physician or midwife)

Address

Krusin Idaps

Filed

No 15 1927 M.R. Halerhauer

Registrar.

Registrar.



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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JAN 23 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonanza

City of Moravia

CERTIFICATE OF BIRTH

No. 363 123 011 845 St. Registration District No. 79 State File No. 158491

Hospital _____ Primary Registration District No. 7156 Local Registrar's No. _____

FULL NAME OF CHILD Storace Gole

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <input checked="" type="checkbox"/> and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 23</u> 192 <u>7</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Ag. Nos.

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Chas. Eugene Gole
RESIDENCE Moravia, Ida.
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE S. Dak.
OCCUPATION Farmer.

MOTHER
FULL MAIDEN NAME Blanche Youngbluth
RESIDENCE Moravia, Ida.
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Iowa
OCCUPATION Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9.30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) S. E. Fry
Physician
(Physician or midwife)

Address Bonanza Ferry, Ida.

Filed Nov. 26 1927 S. E. Fry.

Registrar.

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 23 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

60249

State File No.

PLACE OF DEATH

County of Boundary
City of Moravia

Registration District No. 29
Primary Registration District No. 2156
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Storace Cole, Jr.

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) ✓

5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 23-1927

7 AGE stillborn Year Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9 BIRTHPLACE (city or town) Moravia, Ida.
(State or country)

10 NAME OF FATHER Chas. Eugene Cole

11 BIRTHPLACE OF FATHER (city or town) Yankton, S. Dak.
(State or country)

12 MAIDEN NAME OF MOTHER Blanch Thompson

13 BIRTHPLACE OF MOTHER (city or town) Webb Iowa
(State or country)

14 Informant Chas E Cole
(Address) Moravia, Ida.

15 Filled Nov. 23 1927 Geo. Wilson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 23 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to 19.....
that I last saw h..... alive on 19.....
and that death occurred, on the date stated above, at 9.30 P. m.
The CAUSE OF DEATH* was as follows:

Stillborn
(Died in utero)
(duration) yrs. mos. 3 ds.
CONTRIBUTORY Disease of placenta - hemorrhage
(Secondary)

(duration) yrs. mos. ds.
18 Where was disease contracted
If not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Geo. Wilson, M. D.
Nov. 23 1927 (Address) Bonanza, Ky.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Moravia, Ida. Date of Burial Nov. 24 1927

20. Undertaker Geo. Wilson Address Naples, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic Interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED MAR 7 1928** STATE OF IDAHO
County of Bonneville DEPARTMENT OF PUBLIC WELFARE
City of Idaho Falls Ida. BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 753111 010-245 St. 2 Registration District No. 73 State File No. 159157
(If born in hospital or institution give name.) Prim. Registration District No. 2142 Local Registrar's No. A2
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate Yes Date of birth 10-11-1927
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?
Number of child of this mother, including present birth _____ (a) Born alive and now living _____
Born alive but now dead _____ Stillborn _____
FATHER FULL NAME Wm A. Peterson FULL MAIDEN NAME Inella Kunz
Residence (Usual place of abode) Idaho Falls Ida. Residence (Usual place of abode) Idaho Falls Ida.
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 36 Color or race White Age at last Birthday 24
Birthplace Idaho Falls Idaho Birthplace Triggs Idaho
(City and State or Country) (City and State or Country)
Occupation Farmer Occupation Teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn M.
on the date above stated.

(Signature) Dr. H. H. Hall

(Physician or midwife)

Address _____

Filed Set 1 19 28

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF OHIO
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Registration District No. _____
 Prior Registration District No. _____
 (If different, indicate the word "different" for name of child)

Name of child _____
 Sex _____
 Date of birth _____
 Legitimacy _____
 (To be answered only in case of legal birth)

Was prophylaxis used to prevent *Opthalmia Neonatorum*? _____
 (a) born alive and now living _____
 (b) born dead _____
 (c) stillborn _____

Name of mother _____
 Name of father _____
 Residence (usual place of abode) _____
 In household, give place and State _____
 Color of race _____
 Age at last birthday (Years) _____
 Birthplace _____
 (City and State or Country) _____
 Occupation _____
 (City and State or Country) _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 (Signature) _____
 Address _____
 City _____

If there were no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS, COLUMBUS, OHIO.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 3 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 59192

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonanza Registration District No. 13
City of Idaho Falls Primary Registration District No. 21470

Local Registrar's No. 136

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard Peterson

(a) Residence. No. 302-8 St. Idaho Falls Ida.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 11/27

7 AGE Years Months Days 1 day or LESS than 1 day or 0 hrs. min. 0 0 0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10 NAME OF FATHER Wm. A. Peterson

11 BIRTHPLACE OF FATHER (city or town) Idaho Falls, Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Luella King

13 BIRTHPLACE OF MOTHER (city or town) Driggs, Idaho
(State or country)

14 Informant Wm. A. Peterson
(Address) Idaho Falls, Idaho

15 Filed Oct 11, 1927 Wm. A. Peterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 11, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 6:30 am. The CAUSE OF DEATH* was as follows:

Still born

CONTRIBUTORY (Secondary) _____

_____ (duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted _____

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Dr. Hollister

(Signed) _____, M. D.

Oct 11, 1927 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial Oct 12, 1927

20. Undertaker R. F. McMan Address Idaho Falls, Idaho

JUL 2 1974

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED MAR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

349101014666
County of Carney
City of Nampa

CERTIFICATE OF BIRTH 159260

No. _____ St. _____ Registration District No. 7 State File No. _____
Hospital Nazarene Primary Registration District No. 1006 Local Registrar's No. 13
FULL NAME OF CHILD Infant Turton

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth Dec. 31 1927
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? argyrol

Number of child of this mother, including present birth one Number of child of this mother now living, including present birth none

FATHER
FULL NAME Richard H. Turton
RESIDENCE Nampa Idaho
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Myrtle Mae Woods
RESIDENCE Nampa Idaho
COLOR It like AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE De Kalb, Ill.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Geo. Proctor

Physician
(Physician or midwife)

Address Nampa, Idaho

Filed 3-5

1928

Registrar.

Registrar.

RECEIVED BY THE BUREAU OF VITAL STATISTICS
 COUNTY OF [illegible] STATE OF [illegible]
 JAN 10 1910

CERTIFICATE OF BIRTH

County of [illegible] State of [illegible]

No. [illegible] Registration District No. [illegible]

Primary Registration District No. [illegible] Hospital [illegible]

FULL NAME OF CHILD

(Certificate of no name without full name of child)

Sex of Child [illegible]
 (To be answered only in case of child birth)

Legal Name [illegible]

Date of Birth [illegible]

(Month)

What pathological condition was used in case?

Number of birth of this mother, including present birth

Number of birth of this mother now living, including present birth

FATHER

MOTHER

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was [illegible] at [illegible]

When there was no attending physician to attend the labor, the mother should make this return. A child born to one that neither mother nor shows other evidence of life after birth. With names added from a pathological report.

(Signature)

(Physician or Midwife)

Address

Filed

Registration

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **60274**

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2106
(No. Hagerman Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Mr & Mrs R. H. Turtora
(a) Residence. No. 2 miles N of Nampa St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>		
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6. DATE OF BIRTH (month, day and year)				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				
9. BIRTHPLACE (city or town) (State or country) <u>Nampa Ida</u>				
10. NAME OF FATHER <u>Richard H. Turtora</u>				
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Idaho</u>				
12. MAIDEN NAME OF MOTHER <u>Myrtle Woods</u>				
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Idaho</u>				
14. Informant <u>R. H. Turtora</u> (Address) <u>R. R. 3, Nampa Ida</u>				
15. Filed <u>2-10</u> , 19 <u>28</u> <u>Mal Herby</u> Registrar				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>Dec</u> <u>31</u> 19 <u>27</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h. _____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Re natal toxemia from severe malnutrition</u> (duration) _____ yrs. _____ mos. _____ ds. CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds. 18. Where was disease contracted if not at place of death? Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? (Signed) <u>Geo. R. Groat</u> M. D. <u>1-6-1928</u> (Address) <u>Nampa</u>	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. Place of Burial, Cremation, or Removal <u>Rocklawn Cem</u>	Date of Burial <u>1-3</u> 19 <u>28</u>
20. Undertaker <u>J. H. Robinson</u>	Address <u>Nampa</u>

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None. A

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

78-19-027-254
PLACE OF BIRTH RECEIVED APR 13 1928 STATE OF IDAHO
County of Boone DEPARTMENT OF PUBLIC WELFARE
City of Boone BUREAU OF VITAL STATISTICS
No. _____ St. _____ CERTIFICATE OF BIRTH **S** 160214
Registration District No. 23 State File No. _____
(If born in hospital or institution give name.) Prim. Registration District No. 207 Local Registrar's No. 12
FULL NAME OF CHILD Stella
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child M Twin Triplet or other? no and Number in order of birth 1 Legitimate yes Date of birth Oct. 19 1927
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____
Number of child of this mother, including present birth 1 (a) Born alive and now living 1
Born alive but now dead _____ Stillborn _____
FATHER FULL MAIDEN NAME MOTHER
FULL NAME Clayton B. Harrison NAME Netta A. Bude
Residence (Usual place of abode) Boone Residence (Usual place of abode) Boone
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 25 Color or race White Age at last Birthday 25
(Years) (Years)
Birthplace Idaho Birthplace Idaho
(City and State or Country) (City and State or Country)
Occupation Mgr. Sewing Station Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 3:30 P.M.
on the date above stated. Stillborn

(Signature)

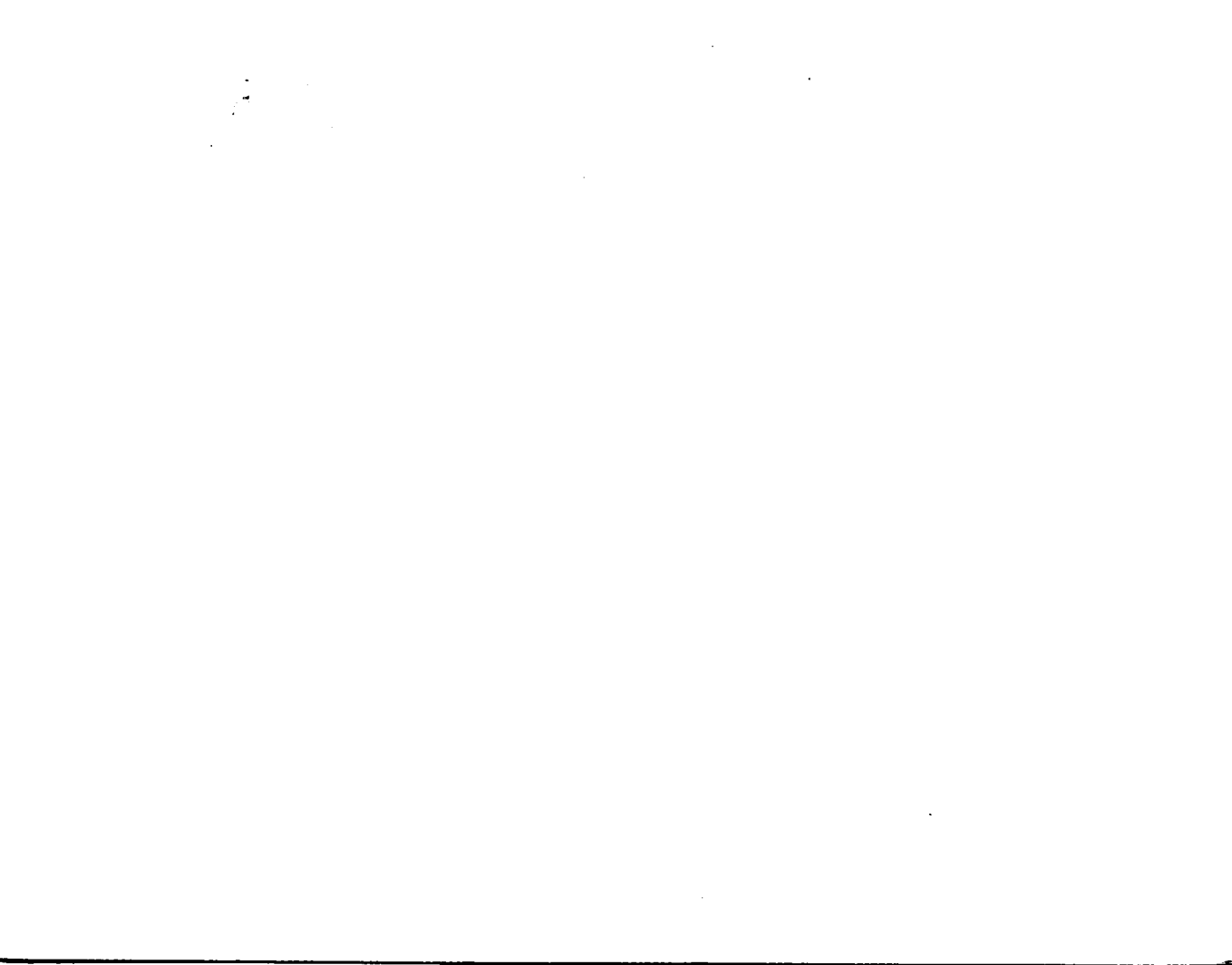
Dr. C. J. Keller
Per: C. J. Keller
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 4-6 1928 Elk River

Registrar.



Registrar

RECEIVED
JAN 10 1944
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

MAILED 10 11 PM
JAN 10 1944
[Illegible text]

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
BUREAU OF ALIEN AFFAIRS
[Illegible text]

[Large block of illegible text, possibly a letter or report, with significant noise and distortion]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 3 1928

STATE OF IDAHO

County of Bannock

DEPARTMENT OF PUBLIC WELFARE

City of Grange

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. 713207003253 St.

Registration District No. 24

State File No. 1625379

(If born in hospital or institution
give name.)

Prim. Registration District No. 246 Local Registrar's No. 779

FULL NAME OF CHILD Baby Jack Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate <u>yes</u>	Date of birth <u>Aug 7 1927</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1st (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Elmer Pack</u>	MOTHER FULL MAIDEN NAME <u>Beckstead</u>
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Residence (Usual place of abode) Grange, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 26 (Years)

Birthplace Utah (City and State or Country)

Occupation Carpenter

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 4 A. M.
on the date above stated.

(Signature) John Hubbard

(Physician or midwife)

Address Grange, Idaho

Filed Aug 30 1928 W. E. G. T. H.
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

